Monitoring and Continuing Education System

CENTRAL TECHNICAL COMMITTEE ON
HEALTH AND NUTRITION
All India Institute of Medical Sciences
New Delhi-110029

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Monitoring and Continuing Education System—1986
ICDS

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FOREWORD

ICDS programme has completed 10 years of its existence. There are rare examples in the world where in such a short time, a National Programme for children expanded so vastely and so quickly. Further, the expansion has not due to an emotional outburst of the planners or the political leaders, but it has been a well considered policy decision, based on adequate objective and subjective information on the performance of the scheme.

One of the important characteristics of the ICDS is establishment of a process for continuous review of the system meant for improving the quality of the functionaries and better implementation of the programme. This unique feature of ICDS has been a very valuable contribution not only to this National Programme, but also has become an example to be followed up for other National Programmes.

There has also been an effort to continuously simplify the monitoring system based on the experience of all the workers from periphery to the Centre. The monitoring system in ICDS has been modified four times during the last 10 years. This document which has been prepared by the Central Cell with special efforts of its monitoring division, describes the functions of each category of persons involved in monitoring and several details of its different aspects. It also describes the subject of continued education in ICDS. I hope that this monogram would be useful to all the functionaries of ICDS.

October, 1988

B N TANDON

CONTENTS

		Page
I	Introduction	1
II	Evolution of Monitoring Strategy	3
III	Administrative and Monitoring Set up	5
IV	Current Monitoring Strategy	14
V	Guidelines to Monitor Monthly Performance of Health and Nutrition Component of ICDS	19
VI	Financial Assistance under new Monitoring System	36
VII	Continuing Education, the Present Strategy	40
VIII	Syllabus in Continuing Education	44
IX	Health and Nutrition Education Messages	80
X	Formats	90
XI	Appendices	123

ABBREVIATIONS

AIIMS	— All India Institute of Medical Sciences
ANM	— Auxiliary Nurse-Midwife
AW	— Anganwadi
AWW	— Anganwadi Worker
CDPO	— Child Development Project Officer
CDA	— Chief District Adviser
CMO	— Chief Medical Officer
CTC	— Central Technical Committee
DA	— District Adviser
DPT	— Diphtheria, Pertusis, Tetanus
DFWPO	— District Family Welfare Planning Officer
DHO	— District Health Officer
DMOH	— District Medical Officer Health
EPI	— Expanded Programme of Immunization
HQ	— Head Quarter
ICDS	— Integrated Child Development Services
LHV	— Lady Health Visitor
MMR	— Monthly Monitoring Report
MO	— Medical Officer
MPR	— Monthly Progress Report
MPHW (F)	— Multipurpose Health Worker (Female)
MS	— Mukhya Sevika
ODA	— Officer In Charge Data Analysis
PA	— Project Advisor
PHC	— Primary Health Centre

Sr. A	— Senior Adviser
SA	— Sectoral Adviser
SC	— State Coordinator
SHC	— Subsidiary Health Centre
TT	— Tetanus Toxoid

I. INTRODUCTION

Integrated Child Development Services Scheme was launched on 2nd October, 1975 in pursuance of the national policy for children, in 33 experimental blocks. Success of the scheme prompted expansion of ICDS to over 1000 blocks by the end of Sixth Plan (1984-85). During the seventh plan, Programme is likely to expand to another 1000 blocks.

ICDS is a **multi-sectoral programme** and involves several departments, whose services are coordinated at the village, PHC, project district and state levels. The primary responsibility for the implementation of the programme lies with the Department of Women and child development, Ministry of Human Resource Development at the centre and the nodal departments at the state which may be Social Welfare, Rural Development, Tribal Welfare or Health and Family Welfare.

The ICDS beneficiaries are **children below 6 years, pregnant** and **lactating women** and **women in the age group 15 to 44 years.** The beneficiaries are to a large extent identical with those under the MCH and EPI programmes.

The infrastructure of ICDS is an additional facility which can be profitably used to supplement the health, nutrition and family welfare activities with appropriate co-operation and co-ordination between functionaries of the departments viz., health and the nodal departments.

The objectives of ICDS are :—

(i) To improve the nutritional and health status of children in the age group 0-6 years; (0-71 months);

(ii) To lay the foundations for proper psychological, physical and social development of the child;

(iii) To reduce the incidence of mortality, morbid malnutrition and school drop-out.

(iv) To achieve effective co-ordination of policy a implementation amongst the various departments promote child development; and

(v) To enhance the capability of the mother to l after the normal health and nutritional ne through nutrition and health education

Towards achieving these objectives, a **package of servi** is rendered through the Anganwadi Worker at the villa centre called **Anganwadi**. The **supportive supervision by functionaries of the Nodal department** and health departm is essential for the success of the programme.

The Social Welfare functionaries have a primary respo sibility of providing supplementary nutrition and non-f rm education to the beneficiaries of the programme.

The functionaries of the Health Department play a ma role in monitoring of health aspects at different levels on t following pattern:

State Head Quarter

(i) State Co-ordinator (SC)

(ii) Senior Adviser (Sr. A)

(iii) Officer I C Data Analysis (ODA)

District Head Quarters

(i) Chief District Adviser (CDA)

(ii) District Advisers (DA)

Primary Health Centre

(i) Project Adviser (PA)

(ii) Sectoral Advisers (SA)

II. EVOLUTION OF MONITORING STRATEGY

In view of the rapid expansion of the scheme, the system of monitoring has been continuously evolving over the years. The strategy of monitoring of health component has changed in a phased manner. The current phase being "Modified Monitoring and Continuing Education-1985". In each phase, increasing number of health functionaries were involved at different levels for monitoring health component of ICDS.

First Phase (October 1975 to October 1978) : monitoring was carried out by Consultants in the departments of Pediatrics and Community Medicine at medical colleges in 33 pilot projects. The Consultants were responsible for Survey, Monitoring and Training.

Second Phase (November 1978 to June 1981 : The number of projects increased from 50 to 150. Senior officers of the state Public Health Department and District Pediatricians were also involved as consultants for monitoring of projects.

Third Phase (July 1981 to March 1985) : Medical Officers incharge, Primary Health Centre at project level, District Health or District Medical Officers (District Advisers) at district level and senior officers at state level (State Coordinators, Senior Advisers and Officers Incharge Data Analysis Cell) were entrusted the responsibility of monitoring. In this phase Monthly Monitoring Reports (MMRs) from Anganwadi Workers (AWWs) were compiled by MO Incharge PHC and submitted to Advisers, after scrutiny and comments. The Advisers then prepared a consolidated report in the prescribed format at district level and submitted the same directly to Central Cell with a copy to the State Coordinator.

In 1982, Medical Officers of the PHCs and District Advisers were given responsibility of continuing education at project, sector and peripheral level. After Annual Convention 1983, the advisers and M.Os. were given a format to make report at the end of each quarter for continuing education carried out by them at project/sector level and by MOs of primary health centres at sector level. Place, date and subject of continuing education alongwith the nature and number of participants were reported.

In 1983, after 2 years of the 3rd phase, the report of medical officer incharge included information on staff, supply position of drugs, vaccines, Anganwadis visited, sectoral training and immunization activities and vital statistics. They submitted their MMRs directly to the Central Cell on prescribed format with copies to the State Coordinator. This procedure of reporting gave early information to the Central Cell.

Computerised system to analyse data was introduced at the Central Cell in September, 1984. Analysis of data was done in 8 tables—I, II, III & IV giving projectwise information of each state while tables V, VI, VII & VIII gave information for statewise comparison. This computerised data of each month was sent to the Ministry of Social Welfare, State Directors of Social Welfare and the State Co-ordinators alongwith the comments of the Central Cell.

III. ADMINISTRATIVE AND MONITORING SET UP

Monitoring of the Health and Nutrition Components is an important activity in the ICDS project. It is to assess the progress and the quality of services being rendered. This helps the functionaries and scheme implementers to adopt necessary changes and to institute mid-course corrections in the programme.

At present there are two types of monitoring systems in ICDS. In both cases, the report begins from the Anganwadi Worker. One report entitled "Monthly Progress Report "MPR" relates primarily to the Social Welfare Components and the other "Monthly Monitoring Report" concerns with health and nutrition components. These reports flow to different channels and are analysed ultimately by the Ministry of women and child development and the Central Technical Committee at All India Institute of Medical Sciences (AIIMS) New Delhi, respectively.

The Central Technical Committee on Health and Nutrition (CTC) was constituted in 1976 under the Chairmanship of Dr. B.N. Tandon at the All India Institute of Medical Sciences, New Delhi to monitor and evaluate the health and nutrition components of ICDS. The CTC established a Central Cell at AIIMS with the following functions :

(i) Assist in monitoring of the helath and nutrition components of ICDS;

(ii) Evaluation of the flow of services and their impact with special reference to health and nutrition.

(iii) Orientation and training of Medical Officers of ICDS projects.

An ICDS project may be started in a rural, tribal or urban slum area. Approximate population in an ICDS project may be 100,000, 35,000 and 100,000 in rural, tribal and urban slum areas respectively. An Anganwadi Worker, a local lady is selected as an honorary worker to serve a population of 1000 in rural, or urban and population of 700 in a tribal ICDS project. Thus on an average, one AWW (in rural and urban areas) caters to 170 children in 0-6 years age group, about 30 pregnant women (of all trimesters), 15 lactating women (in first 6 months of lactation) and about 200 women in the reproductive age group (15-45 years). In tribal areas, the numbers would be reduced proportionately.

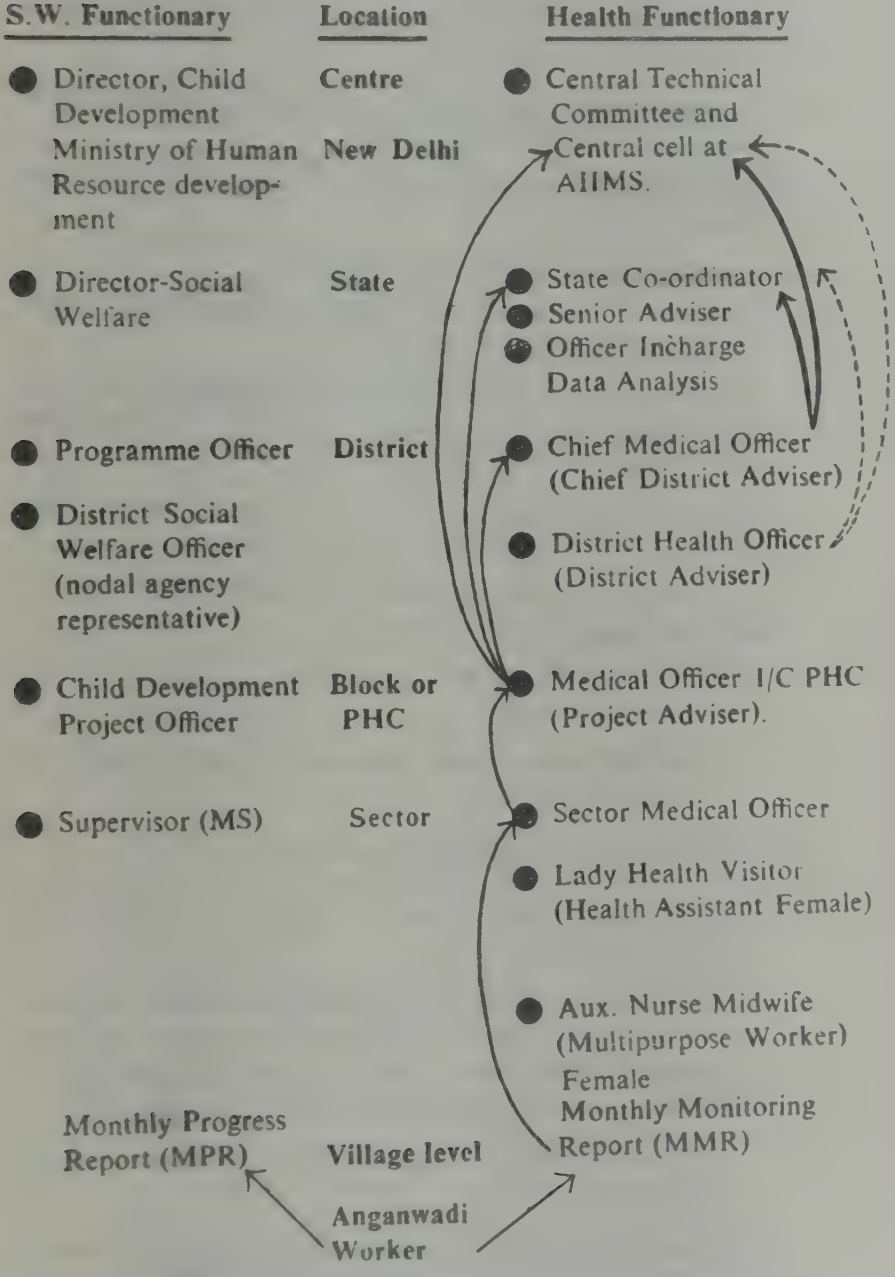
On the social welfare side, there is a supervisor (Mukhyasevika) for every 20 or 17 or 25 anganwadi centres in rural, tribal and urban projects respectively. On the health side there are ANMs and LHVs in rural and tribal blocks and only ANMs in the urban projects. The exact ratio varies from project to project depending on the stage of upgradation of PHCs, adoption of Multipurpose Workers Scheme etc. It is envisaged that for a population of 5000 in rural areas and 3000 in tribal areas there will be one ANM and for every 5 ANM there will be one LHV. For each urban ICDS project, there are 4-6 ANMs. The number of Medical Officers will vary from state to state depending upon the number of PHCs, dispenseries, subcentres, etc. However, in general there are 3 Medical Officers for every PHC (except in urban project where there is only one MO).

The channel of flow of the monitoring reports is illustrated on page 7

I. FUNCTIONS OF STATE CO-ORDINATOR

1. To liase with the state nodal department.
2. To initiate actions for the appointment of Senior Adviser, Officer-in-Charge Data Analysis Cell and Consultants,
3. To take steps for the appointment of Chief District Advisers, District Advisers, and Project Advisers and allotment of operational projects to them.

Flow of monitoring reports



4. To facilitate the ICDS projects with the maximum possible inputs of health functionaries.

5. To divide the ICDS projects amongst the Consultants for specified functions.

6. To ensure adequate supply of medicines, vaccines, equipment etc. in ICDS project areas.

7. To facilitate consultants' work in training, survey and research.

8. To organise State Quarterly Meetings.

9. To ensure the regular and timely submission of reports by the functionaries of the state.

10. To take necessary steps to improve the quality of monitoring on the basis of the *monthly feed-back received from* the Central Cell.

11. To take part in training courses for social welfare functionaries.

12. To submit the following reports to the Central Cell, on the prescribed proforma (Format 7).

    (i) Quarterly progress report within 45 days after the end of each quarter.

    (ii) quarterly expenditure statement within 15 days after the end of each quarter.

II. FUNCTIONS OF SENIOR ADVISER

1. To ensure that ICDS projects of the State/UT are being monitored regularly.

2. To participate in district level monthly meetings by rotation so that each district's ICDS performance is reviewed on the spot at least once a year or more A short report should be forwarded to the Central Cell after each visit.

3. To review and ensure the quality of the continuing education at the sectoral level.

4. To visit at least one ICDS project each month and **submit the report to the Central Cell and State Coordinator.**

5. To liase with the State Co-ordinator on various problems of individual projects on the basis of observations made during his field visits, reports received by State Co-ordinator and monthly feed-back received from the Central Cell.

6. To attend District Level Seminars being organised by the Social Welfare functionaries.

7. To take part in training courses for Social Welfare functionaries.

8. To submit the following reports to the Central Cell, on the prescribed proforma (Format 6).

   (i) quarterly progress report within 30 days after the end of each quarter.

   (ii) quarterly expenditure statement within 15 days after the end of each quarter.

III. FUNCTIONS OF OFFICER-IN-CHARGE DATA ANALYSIS CELL

1. To ensure completion and submission of State Co-ordinator's quarterly report to Central Cell within specified period.

2. To help the State Coordinator in organising state level meetings.

3. To help the State Co-ordinator in initiating necessary actions for improvement in functioning of ICDS projects on the basis of monthly feed-back received from the Central Cell.

4. To monitor the establishment and functional status of ICDS projects sanctioned.

5. To ensure the regular receipt of monthly monitoring returns from the Project Advisers and to formulate appropriate actions for the supply of drugs, vaccines and supplementary nutrition.

6. To prepare monthly summary report on the basis of the MMRs from the various functionaries and the feedback from the Central Cell.

7. To ensure the submission of expenditure statements to the Central Cell at the end of each quarter as specified.

8. To take part in training courses for social welfare functionaries.

IV. FUNCTIONS OF CHIEF DISTRICT ADVISER

Head of the Medical and Health department at the district headquarter is designated as Chief District Adviser.

1. To distribute ICDS projects amongst the District Advisers as per guidelines from the Central Cell.

2. To depute the District Advisers and Medical Officers for orientation training courses conducted by the Consultants.

3. To organise district level monthly meeting with District Advisers, Project Advisers and CDPOs, to review the progress and to resolve the difficulties, for effective implementation of the programme.

4. To take a lecture at the district level meeting on one of the subjects listed in section VII as a part of continuing education.

5. **To report to the Central Cell by 21st of each month about monthly progress review** on the prescribed proforma (Format 5.).

6. To participate in all the State Quarterly Meetings and report the progress of ICDS projects in his district.

7. To receive the grant for himself and to submit the Quarterly Expenditure Statement within 15 days after the end of each quarter, on the prescribed proforma B (Format 9).

8. To ensure that the ICDS project/PHC area is divided amongst the Project and Sectoral Advisers for continuing education and monitoring.

V. FUNCTIONS OF DISTRICT ADVISER

Second level Medical and Health Officials of the district such as Deputy CMO, Additional CMO, DHO, DFPO, District

TB, Malaria and Leprosy Officer, etc. is designated as District Adviser, for the ICDS projects. Generally, one to three ICDS projects are allocated to him.

1. To organise monthly PHC meeting of MOs, CDPO, MSs and LHVs for—

   (i) Continuing education as per guidelines, and

   (ii) Review of the monthly monitoring report of Project Adviser and ensure its timely despatch to the CDA, Central Cell and State Co-ordinator.

2. To take a lecture at the PHC meeting on one of the subjects listed in section VII as part of continuing education.

3. To submit his Monthly monitoring Report to the Central Cell and State Coordinator **within 11 days after the end of each month on the prescribed proforma** (Format 4).

4. To distribute the ICDS project/PHC area amongst the Project and Sectoral Advisers for continuing education and monitoring, with the concurrence of Chief District Adviser.

5. To participate in the —

   (i) District level meeting organised by Chief District Adviser.

   (ii) State Quarterly Meetings (twice a year).

   (iii) District Level Seminars conducted by Social Welfare Functionaries.

6. To deliver lectures for Social Welfare Functionaries.

7. To make the monthly payment, at the time of PHC level meeting to the Project and Sectoral Advisers in the PHCs under his charge for the month under review only.

8. To receive the grant for himself and MOs at the PHCs under him and to submit the Quarterly Expenditure Statement **within 15 days after the end of each quarter on the prescribed proforma** A (Format 8).

VI FUNCTIONS OF PROJECT ADVISER (MO. I/C PHC)

Seniormost Medical Officer of the Primary Health Centre (MO I/C PHC) is designated as Project Adviser.

1. To divide the ICDS project/PHC area for monitoring and continuing education into 4 or 5 Sectors depending upon the number of MSs and allot them to Medical Officers (Sectoral Advisers) with approval of Chief District Adviser/District Adviser. **He must keep one sector under his direct charge.**

2. To prepare Monthly Monitoring Report (MMR) of the PHC on the prescribed proforma (Format 3) with the help of clerk/computer on the basis of the data obtained from the AWW's MMRs (checked by ANMs/LHV and Sectoral Adviser).

3. To present his MMR of the last month, at the Monthly PHC level meeting to the District Adviser and despatch the same to the Central Cell and the State Co-ordinator within **eight days after the end of each month.**

4. To attend monthly district level meeting of Chief District Adviser and report the progress of ICDS project.

5. To attend State quarterly meeting once in a year (by rotation 25% of PAs would participate in each State quarterly meeting).

VII. FUNCTIONS OF SECTORAL ADVISER

Each ICDS Project/PHC is divided into sectors corresponding to the area of one MS. One Medical Officer is made incharge of one sector, who is designated as Sectoral Adviser. This Medical Officer is selected from PHC or SHC or even a dispensary in the PHC area.

1. To arrange a **monthly meeting during the last week of each month** with all AWWs, MPHW F, LHV and MS of the sector at one village of the sector, designated as Sectoral Head Quarter.

2. To review the progress, and initiate actions for improvement of the ICDS services in the sector.

3. To take a class for continuing education at the monthly meeting on one of the subjects listed in continuing education (section VII).

4. To prepare a sectoral report on the prescribed proforma (Format 2) and submit it along with the AWW's MMRs to the project adviser (MO I/C PHC) **latest by 30th of the month**.

IV. CURRENT MONITORING STRATEGY

The current system of reporting by MO incharge PHC adopted from March 1985, is known as "Monitoring and Continuing Education System".

In this strategy the **unit of monitoring of health and nutrition components of ICDS is PHC** and not the whole project (except in urban ICDS projects). The Formats of MMRs have been revised to have all the health information from MO Incharge PHC.

All Anganwadi Workers' MMRs are compiled and consolidated by MO incharge PHC who has been designated as Project Adviser. He submits the consolidated report directly to Central Cell for preparation of computerised tables. This helps in expeditious flow of data from the projects to the Central Cell.

The CMO or DMOH is actively involved in monitoring as a Chief District Adviser.

Continuing education at sector level, PHC level, district and state level has been intensified.

1. ANGANWADI CENTRE

At present, the Monitoring of Aganwadi Centre is done by using the Anganwadi Worker's monthly Monitoring report (Format I). The report is prepared by AWW for each month (from 26th of previous month to the 25th of the current month under report). The MMR so prepared is scrutinised by the ANM/LHV responsible for the Anganwadi.

2. SECTOR

Each sector generally comprises of 20 AW centres in a rural ICDS project and 17 AW centres in a tribal ICDS project. **Each sector corresponds to the areas of one Supervisor** (Mukhya Sevika). The health functionaries of the PHC, subcentres and rural dispensaries have been allocated respective sector for their health duties. The sectoral headquarter may be a subcentre, rural dispensary or even the PHC depending on the area of the sector. **One of the Medical Officers from the total PHC area (regardless of his funding or place of work, PHC/Subcentre/dispensary) is designated as Sectoral Advisor** and he is responsible for the monitoring and continuing education of the functionaries of the sector under his charge. **For this he shall organise between 26th to 30th of every month,** a sectoral meeting which will be attended by all AWWs, ANMs, LHV and MS (Supervisor) working in the sector. The functions of Sectoral Advisor are outlined in Section III, P. 12.

3. PRIMARY HEALTH CENTRE

The seniormost medical officer of the PHC or the M.O. incharge of the PHC is designated as ICDS Project Adviser. He is the Sectoral Advisor for one of the sectors in the PHC in addition to being a ProjectA dviser. His functions are outlined in Section III, P. 12.

4. DISTRICT

At district level monitoring & continued education is carried out by District Advisors and Chief District Adviser.

4.1 District Adviser—Every District shall have District Adviser (s) looking after one or more ICDS project in the district. The District Adviser shall be one of the key officials in the District Health Office. He may be Chief Medical Officer or one of his deputies looking after Public Health, Malaria, Family Welfare, Tuberculosis, Leprosy or any other health programme.

The regular PHC level meeting which is held in most States in the first week of every month shall also be attended by the

District Adviser. **It is desirable to organise this meeting between 4th to 8th day of every month.** His functions are described in detail in Section, III P 10.

4.2 Chief District Adviser

The head of the medical and health department at the district viz. the Chief Medical Officer/District Health Officer/ Civil Surgeon/District Medical Officer of Health is designated as Chief District Adviser whose functions are detailed in Section III, P 10.

5. STATE

Monitoring and Continuing Education at state level is the responsibility of State Coordinator, Senior Advisor and Officer in-charge Data Analysis. Their functions are described in Section III PP, 6, 8 & 9.

MONITORING OF URBAN ICDS PROJECTS

Monitoring and Continuing Education is responsibility of three types of Functionaries in urban projects.

1) **Medical College Consultants,**

2) **Municipal Health Officers, and**

3) **District Medical and Health Officers or CMOs.**

The monitoring system has been developed and implemented according to local needs of the State. The varying health infrastructure facilities available in urban projects have been kept in view while developing the system.

I. Medical College Consultants—when the urban projects are situated close to the medical colleges :

The consultants have been identified from the faculty of different departments in medical colleges. The functions of consultant would be like district adviser as outlined on page 10 and he will be responsible for one or more ICDS projects depending upon the number of projects functioning in the urban area.

In general, in each project, the medical officer sanctioned from ICDS grants would act as the Project Adviser. His functions are :—

1. He will divide the project into sectors (usually four), equal to the number of MSs. Sector headquater may be an MCH centre/dispensary or other suitable place.

2. He would regularly visit all the anganwadis of the project by rotation, 10-12 each month. He will conduct sectoral level meetings for monitoring and continuing education in all the 4 sectors from 26th to the last date of the month. The meeting will be attended by all the anganwadi workers of the sector, MS and ANM/LHV.

3. He will collect the AWWs' reports, scrutinise and suggest measures for improvements of ICDs activities.

4. He will take a session of 30 minutes for continuing education on one of the subjects listed in Section VII.

5. He will prepare MMR of the urban project with the help of LHV or some other assistant from the basic data given in all the AWWs MMRs. He will send project Adviser's report to the Central Cell by 8th of the following month and one copy to the State Coordinator. He will present his report for review at the project level meeting conducted by the consultant each month.

The consultant would organise a monthly monitoring review meeting with the project adviser, ANMs, LHVs AWWs and other staff during the first week of the month and review the progress of ICDS activities. The consultant would also take a lecture for continuing education during the meeting. A minimum of *three* hours would be spent during the project review meeting.

Consultant would make at least two field visits to each of the projects allotted to him every month and review the implementation of ICDS activities at the Anganwadi level.

Consultant would also be responsible for training survey and research activities given to him from time to time.

II. Municipal Health Officer or his Deputies in the Corporations and large municipalities.

The Central Cell with the help of local authorities would identify an urban Consultant/Urban Adviser for ICDS projects from amongst the Municipal Health Officer and his Deputies. He would supervise and monitor the urban ICDS projects as done by Medical College Consultant. He would conduct the monthly project meeting and ensure that the MMR of the urban project is despatched to Central Cell by the Project Adviser (MO, ICDS Project), before 8th of the following month.

III. Chief Medical Officer of the district (CDA) or his Deputies (DAs) in urban areas having small municipalities.

Usually the adequate infrastructure is not available in these areas. CDA will himself or his DA would supervise and monitor the urban project and conduct the monthly project meeting. He will have similar functions as in rural ICDS projects (P. 10) The MO appointed from ICDS grant will function as Project Advisor and discharge the duties as outlined for urban projects on (P. 17)

Monitoring system of urban projects in Delhi and Tamil Nadu has been designed in consultation with the health authority of the Union territory and the State respectively.

V. GUIDELINES TO MONITOR MONTHLY PERFORMANCE OF HEALTH AND NUTRITION COMPONENT OF ICDS

For regular assessment of the work done in an anganwadi area and to know the trend of various parameters of health and nutrition, certain indicators have been identified and included in the Monthly Monitoring Report. The MMRs are received from every PHC/Urban project, by the Central Cell directly from the Project Advisers. These reports are coded and analysed with the help of computer. The analysed data is then sent to the Government of India and state Health Departments (State Co-ordinators/Sr. Advisers) with comments of the Central Cell.

The major areas monitored by this system are —

1. **Vital events** — (a) Birth rate
   (b) Still-birth rate
   (c) Infant mortality rate
   (d) Toddler mortality rate
   (e) Modified Maternal mortality rate

2. **Nutritional Status** — Malnutrition

3. **Immunization Status** — (a) BCG-1 dose
   (b) DPT—3 doses } For children 0—11 months
   (c) Polio—3 doses }
   (d) TT for pregnant women-2 doses

4. **Pregnant and Lactating Women** — Prevalence Rates

It is important for functionaries like Consultants, State Co-ordinators, Senior Advisers, Officers-in-charge Data Analysis Cell, Chief District Advisers, District Advisers, Project and Sectoral Advisers who are actively involved in monitoring to understand the basis of these indicators. An attempt has been made to illustrate with examples the basis of indicators used in monthly monitoring reports of AWW and M.O.I/C PHC. This will enhance the understanding of the health status of a particular area, allow easier comprehension of the data, and the comments that are sent to the states from the Central Cell. The project data collected may be compared with –

(a) National Health Statistics,

(b) State Health Statistics,

(c) Targets for the nation/state, under 'Health for all by the year 2000 A.D',

(d) District/Project/PHC Health Statistics (where available).

(e) Previous year's/month's, ICDS data.

1. VITAL EVENTS

Some of the vital events which can be easily reported by the Anganwadi Workers have been included in their Monthly Monitoring Reports. They are reported by the AWW in two ways :

(i) Total number of events in the month under report.

(ii) Progressive total since last 26th December.

The national averages for various indicators have been used as reference standards against which comparisons have been made. These are approximations of the averages for the states and by no means are to be taken as absolute figures for the state.

It must be noted that for the purpose of Monitoring, the Month under report is from 26th day of the last month to 25th day of the month under report.

Birth rate is defined as number of births per 1000 population of the project/state. Infant mortality rate of an area is the number of infant deaths per 1000 live births in a year. It is also possible to get the approximate estimates of such age specific populations, from the figures of total population. This has been explained in examples below.

1.1 Birth Rate

About 30 births take place every year in a population of 1000, the population of an anganwadi area (3000 births in a project with a population of 100,000). Thus we can expect each month about $30/12 = 2.5$ births in an area with a population of 1000 (250 births in a project with a population of 100,000). The birth rates can be assessed during a particular month and also total since 26th December till the 25th of the month under report.

Example I

To compare the birth rate with the national (reference) figures, calculate the total number of births reported in a month, divide it by the population in thousands and multiply the figure by 12. This gives the birth rate.

80 births were reported in January 1985 in a population of 40,000, calculate the birth rate.

$$\text{Birth rate for Jan. 85} = \frac{80}{40000} \times 1000 = 2$$

$$\text{Birth rate for the year} = 2 \times 12 = 24/1000$$

The Possible reasons of lower birth rate as compared to national average may be

(1) Under reporting of births,

(2) Monthly variation,

(3) Reduction due to effective family welfare programme,

Example II

To compare the birth rate with national (reference) figure in a specified number of months. First, calculate the total number of births in the population in the specified number of months mentioned earlier. The birth rate can be calculated by the following formula :

$$= \frac{\text{Total No. of births in specified number of months}}{\text{population reported}} \times 1000 \times \frac{12}{\text{specified no. of months}}$$

If the number of births in a reported population of 40,000 in four months is 300, then

$$\text{Birth rate} = \frac{300}{40{,}000} \times 1000 \times \frac{12}{4} = 22.5/1000$$

1.2 Still-birth Rate

Still-birth rate is calculated as follows :

$$= \frac{\text{Total No. of Still-births}}{\text{Total No. of Still births} + \text{No. of live Births}} \times 1000$$

The average still-birth rate of India is around 15/1000 births or 1.5%.

In a project with reported population of 40000 in a particular month, the number of live births is 100 and still-births 2, the still-birth rate will be—

$$\text{Still-birth rate} = \frac{2}{100 + 2} \times 1000 = 19.6/1000$$

The still-birth rate of 19.6/1000 births is higher as compared to that of the national average of 15/1000 births.

This can be due to :—

(1) Abortions being counted as still-births

(2) Poor ante-natal or intra-natal services in an area.

1.3 Infant Mortality Rate

Infant mortality rate in a particular area is the number of infant deaths per 1000 live births in the same year. The national infant mortality rate is 100/1000 live births. In the monthly monitoring reports, the information on the births and infant deaths is given during the month under report and also the total infant deaths from 26th December till the 25th day of the month under report. Accordingly, two methods of calculating infant mortality rate, are available.

Example I.

$$\text{Infant mortality rate} = \frac{\text{No. of infant deaths in a month}}{\text{No. of live births in that month}} \times 1000$$

Calculate the IMR if the number of live births in March was 120 and the number of infant deaths in the same period was 15.

$$\text{IMR} = \frac{15}{120} \times 1000 = 125 \text{ per } 1000 \text{ live births}$$

Example II

$$\text{IMR} = \frac{\text{No. of infant deaths since 26 December 85 till the month being reported}}{\text{No. of live births from 26 December 85 till the month being reported}} \times 1000$$

A project report for June 85, gave the following information : "Progressive total of live births from 26 December 84 to 25th June 85 as 675," the number of infant deaths for the same period, as 54 and the population reported was 40,000.

Calculate infant mortality rate.

$$\text{IMR} = \frac{54}{675} \times 1000 = 80 \text{ per } 1000 \text{ births}$$

Sometimes, the number of births are not reported. It is still possible to estimate with some degree of approximation, the infant mortality rate, when the reported population and the number of infant deaths are known. This is done on

the basis of the fact that the infant population in India is approximately 3% of the total population. Thus when the number of births is not given, IMR can be calculated by the following methods.

Method A

Calculate IMR when 9 infant deaths took place in the month of April 84 in an area whose reported population is 40,000.

No. of infant deaths in 1 year = $9 \times 12 = 108$

Infant population = $3\% \times 40000 = 1200$

$$\text{IMR} = \frac{108}{1200} \times 1000 = 90 \text{ per } 1000 \text{ live births}$$

Method B

Calculate IMR in a project area having reported population of 40,000. The progressive total of infant deaths reported since 26th December 85 to 25th June 85 was 48.

$$\text{No. of infant deaths in 1 year} = 48 \times \frac{12}{6} = 96$$

Infant population = $3\% \times 40000 = 1200$

IMR = $96/1200 \times 1000 = 80$ per 1000 births.

The IMR can be lower when

(1) there is under reporting or actual decrease in number of infant deaths,

(2) there is over reporting or actual increase in number of births

The IMR can be higher when

(1) there is over reporting or actual increase in number of infant deaths,

(2) there is under reporting or actual decrease in number of births,

While comparing the infant deaths in a particular area with national figure, a simple index can be utilised. The basis for which has been discussed below.

IMR of India is taken as 100 per 1000 live births, i.e. 1/10 or one-tenth of the births. The birth rate of India is 30/1000. The infant deaths will be one-tenth of the live birth i.e. 30/10 = 3 per year in a population of 1000. In one month, it will be 3/12 or 0.25 deaths per 1000 population. So, to get the expected infant deaths in a month in a reported population, multiply the number of thousands of population by 0.25. The actual number of infant deaths can be compared with the value so obtained.

Example I

9 infant deaths were reported in a population of 40,000 in April 85. Compare the infant deaths in the population with national average.

Expected infant deaths in the population of 40,000 in a month will be = $0.25 \times 40 = 10$.

The infant deaths in the reported area during the month is 9 against the expected 10 or 90% of the expected, i.e., slightly less.

Example II

48 infant deaths were reported in a population of 40,000 in six months. Compare the infant deaths in this population with national figure.

Expected infant deaths in the six month period will be $= 0.25 \times 40 \times 6 = 60$. The number of infant deaths in the reported area during the period is 48 which is $48/60 \times 100 =$ 80% of the expected number of infant deaths.

1.4 Toddler Mortality Rate (TMR)

The term toddlers implies children in the pre-school years which excludes infants. In monthly monitoring report toddlers group is 1 year to below 3 years (12 to 35 months) and 3 to below 6 years (36-71 months). TMR being an age specific death rate is calculated from the number of deaths in specific

age group, divided by the population in specific age group and multiplied by one thousand.

● Mortality rate in 1 yr. to below 3 yrs. population

$$= \frac{\text{Deaths in 1 yr. to below 3 yrs. group}}{\text{Total 1 yr to below 3 yrs. population}} \times 1000$$

● Mortality rate in 3 yr. to below 6 yrs. population

$$= \frac{\text{Deaths in 3 yrs. to below 6 yrs. group}}{\text{Total 3 yrs to below 6 yrs. Population}} \times 1000$$

When population in the specific age groups is not known, it may be advisable to use national averages. At present, 6% of the total population is in the age group i yr. to below 3 yrs and 8% of the total population in the age group 3 yr to below 6 years.

Accordingly, the mortality rates would be :

Mortality Rate (1 yr. to below 3 yrs.)

$$= \frac{\text{Deaths in 1 yr to below 3 yrs population}}{\text{6\% of the total population}} \times 1000$$

Mortality Rate (1 yr. to below 3 yrs.)

$$= \frac{\text{Deaths in 3 yrs. to below 6 yrs. population}}{\text{8\% of total population}} \times 1000$$

If the figures in the reported month are utilised, then they will have to be multiplied by 12; if on the other hand, the progressive total is used, they will have to be multiplied by 12 and divided by the number of months. The calculation is illustrated in the following example :

Examples 1

A project/PHC report gave the following information. Calculate the mortality rates in the age groups 1 yr. to below 3 yrs. and 3 yrs to below 6 yrs when the reported population was 40,000.

● In April 85, the no. of deaths in 1 yr. to below 3 yrs. group = 7
Total deaths from 26 Dec. to 25th June 85 (in six months) = 45

In April 85 the no. of deaths in 3 yrs. to below 6 yrs. group = 6

Total deaths from 26th Dec. to 25 June 85 (six Month) = 32.

(a) from the figures in 1 month (April 85)

Death rate in 1 yr. to below 3 yrs population

$$= \frac{\text{Deaths in the age group 1 yr. to below 3 yrs.}}{\text{population in 1 yr to below 3 yrs age group (or 6\% of the total population)}} \times 12 \times 1000$$

$$= \frac{7 \times 12}{40000 \times 6/100} \times 1000 = 35 \text{ per thousand}$$

Death rate in 3 yrs to below 6 yrs population

$$= \frac{\text{Deaths in the age group 3 yrs to below 6 yrs}}{\text{Population in 3 yrs to below 6 yrs age group (or 6\% of the total population)}} \times 12 \times 1000$$

$$= \frac{6 \times 12 \times 1000}{400000 \times 8/100} = 22.5 \text{ per thousand}$$

(b) from the progressive total of deaths in 6 months (for the period 26th December to 25th June 85).

Death rate in 1 yr to below 3 yrs population,

$$= \frac{45 \times 12/6 \times 1000}{40000 \times 6/100} = 37.5 \text{ per thousand}$$

Death rate in 3 yrs to below 6 yrs population

$$= \frac{32 \times 21/6 \times 1000}{40000 \times 8/100} = 20 \text{ per thousand}$$

For purposes of comparison, national averages of death rate are taken as 30 and 20 per 1000 population in 1 yr to below 3 yrs and 3 yrs to below 6 yrs population respectively.

1.5 Maternal Mortality Rate

Maternal Mortality rate is defined as the number of maternal deaths due to pregnancy or puerperal causes per 1000 live births.

In the monthly monitoring reports, we only get information on the number of maternal deaths during delivery. This figure

does not include all maternal deaths. Thus the rate calculated is delivery death rate (DDR).

$$DDR = \frac{\text{No. of maternal deaths during delivery in a year}}{\text{No. of live births in a year}} \times 1000$$

We get two types of information—

(i) no. of deaths during delivery in a particular month and progressive total of deaths during delivery from last 26th December onward, and

(ii) no. of births in the same month and progressive total of no. of births from the last 26th December onward. Accordingly, DDR can be calculated.

Method I

$$DDR = \frac{\text{No. of maternal deaths during delivery in reported month}}{\text{No. of live births in reported month}} \times 1000$$

Method II

$$DDR = \frac{\text{Progressive total of maternal deaths during delivery from the last 26th Dec. onward}}{\text{Progressive total of live births since the last 26th December onward}} \times 1000$$

Example

Calculate DDR from the following data :

Population of the reported area = 40,000

No. of births in April 85 = 80

No. of maternal deaths during delivery in April 85 = 1

Births in the period 26th December to 25th June 85 = 450

Maternal deaths during delivery in period 26th Dec. to 25th June = 2

DDR by Method I

$DDR = \frac{1}{80} \times 1000 = 12.5$ per thousand live births

DDR by method II

$$DDR = \frac{2}{450} \times 1000 = 4.44 \text{ per thousand live births}$$

2. NUTRITIONAL STATUS

The monthly monitoring report of an AW centre/PHC/ project has the following information which may be considered while assessing the nutritional status of the concerned areas :

(1) Total Population in the reported Anganwadi

(2) No. of days supplementary nutrition was distributed during the month.

(3) No. of children in the various grades of malnutrition by weight for age OR mid upper arm circumferance criteria.

Before calculating the various indices/rates it is important to check the following :

(1) **The population in the reported area should include all persons in various age groups.**

(2) The majority of the functioning anganwadi centres in a project PHC area should be distributing supplementary nutrition for more than 15 days in a month.

(3) **Number of children in various grades of malnutrition should include all children covered by the Anganwadi centre viz.—children of ages below 6 years.**

To ensure the above, the supervisors at various levels—ANMs, LHVs, MOs, Project Advisers and District Advisers should check that all the children from 0 yr to below 6 yrs of age are included for nutritional status report.

Generally, 17% of the population is comprised of children below 6 years of age.

Children suffering from Grades III and IV types of malnutrition are considered severely malnourished and Grade II as moderately malnourished. The national averages for the

severely and moderately malnourished children in the 0 yr to below 6 yrs age group is around 8.5% and 25% respectively However, one would expect a lower prevalence of severely malnourished children in ICDS Projects functioning for a few years.

The malnutrition rates of different grades in specific age groups is expressed as a percentage of the total number of children below 6 yrs. The number of children in Grade II (moderate malnutrition) and in Grades III & IV (severe malnutrition) are the numerators and 17% of the total Population is the denominator.

Rate of severely malnourished children

$$= \frac{\text{No. of children in Grade III \& IV}}{17\% \text{ of the reported population}} \times 100$$

Rate of moderately malnourished children

$$= \frac{\text{No. of children in Grade II}}{17\% \text{ of the reported population}} \times 100$$

Example

Calculate the rates of malnourished children in a project with reported population of 40,000 The number of children in various grades of malnutrition are ; Grade II = 1700, Grade III = 260, Grade IV = 90

No. of 0 to below 6 years children in the reported population of the project $= 40000 \times \frac{17}{100} = 6800$

Moderately malnourished children rate

$$= \frac{1700}{6800} \times 100 = 25\%$$

Severely malnourished children rate (in grades III & IV)

$$= \frac{260 + 90}{6800} \times 100 = \frac{350}{6800} \times 100 = 5.14\%$$

3. IMMUNISATION

The monthly monitoring reports give information on immunisation of children and pregnant women. The reporting formats are similar to those followed by the Department of Health and Family Welfare under the Expanded Programme of Immunisation. At present, the information obtained through MMRs gives the Immunisation Coverage in the month under report and progressive total since 1st April till the last day of the month under report. The details include coverage regarding following immunisations : BCG; DPT—1st, 2nd, and 3rd doses; Polio—1st, 2nd and 3rd doses; and tetanus toxoid for pregnant women—1st and 2nd dose.

A major change compared to the rest of the report of P.A. that should be borne in mind is that immunisation coverage information pertains to the entire population included in the PHC, (except in Urban ICDS blocks) and not the population catered by ICDS alone.

The EPI provides for one dose of BCG and 3 doses of DPT and Polio to the child in 3rd to 9th month of age. Two doses of Tetanus toxoid are given to a pregnant women in her 16-36 weeks of pregnancy. As per EPI Schedule the BCG, DPT and Polio *immunisations are* given to children below 1 year.

In an area having population of 100,000 with a birth rate of 30/1000 population and IMR of 100/1000 births the eligible population for these immunisations can be calculated as follows :—

No. of pregnant women = $100,000 \times 0.03 = 3000$

No. of children below 1 year age group (3% of the total population)

$= 100,000 \times 0.03 \times (1 - 0.1)$

$= 100,000 \times 0.03 \times 0.9$

$= 100,000 \times 0.027 = 2700^*$

***Reduction made by 0.1% for the infant deaths.**

The functionaries involved in scrutinising the monthly monitoring reports must ensure that the figures given in the reports include only those of the eligible population who have received the respective immunisations and not those of other age groups. Thus for BCG, DPT, Polio, only the number of children below 1 year, who have received these immunisations should be entered and not those who are above 1 year even if they have received any of these immunisations. This is very important as when the number of children given in the report includes those who are above 1 year, the percentages would go up and give a false impression of adequate coverage.

In the report of the Chief District Adviser, immunisation coverage and population of the entire district is available. It is possible to compute the percentage coverage of children and pregnant women eligible in the entire district and compare with that of the PHC area in the ICDS project.

The report under EPI is prepared every month giving current and cumulative total since 1st April of the year.

Immunisation Coverage is determined as a percentage of number of children immunised against the total number of eligible children in the specific age groups. At present, the analysis at the Central Cell is done for single dose in case of BCG, 3 doses of DPT and 3 doses of Polio,and the base population is considered as below 1 year i.e. 3% of the total population.

Example—Determine the immunisation performance in a PHC with a total population of 100,000 when the immunisation coverage as per MMR for the month of July 1985 was as follows :

No. of children immunised	BCG Single dose	DPT 3 doses	Polio 3 doses	Tet. Toxoid 2 doses (For preg. women)
● In July 1985	27	40	40	30
● Since 1st Apr. 85 to end of July 85	135	432	418	240

Expected coverage in a year in 100, 000 Population

Pregnant women — 3000 (30/1000 of population)

Children below 1 yr — 2700 (3% of population × 0.9)

	Actual coverage : July 85	Progressive total Apr. 85 to July 85 (4 months)
BCG	$\frac{27}{270} \times 100 = 1\%$	$\frac{135}{2700} \times 100 = 5\%$
DPT 3 doses	$\frac{40}{2700} \times 100 = 1.5\%$	$\frac{432}{2700} \times 100 = 16\%$
Polio 3 doses	$\frac{40}{2700} \times 100 = 1.5\%$	$\frac{418 \times 100}{2700} = 15.5\%$
T.T. 2 doses	$\frac{30}{3000} \times 100 = 1\%$	$\frac{240}{3000} \times 100 = 8\%$

For comparison with the performance in the district as a whole, the percentages of district immunisations can be calculated from the monthly monitoring report of the Chief District Adviser.

It is desirable to compare the figures of the progressive totals rather than those given in a particular month as immunisation in a single month may be too poor or too good.

4. PREGNANCY AND LACTATION PREVALENCE RATES

It is not possible to get accurate information on these two items through MMR. However some trend may be known.

4.1 Pregnancy

In a population of 1000 there are about 30 births in a year. Considering the fact that a pregnancy lasts for nine months, it is expected that 30 women would be pregnant in a population of 1000 at any point of time (Pregnancy Prevalence rate). Of this 10 will be in the first trimester (early pregnancies) who may not be enrolled as pregnant in the registers of AWWs, ANMs or LHVs. Thus, in a population of 100,000, the number of pregnant women expected in any month should be 2000 (second and third

trimester) who should be enrolled with AWWs, for ante-natal services, tetanus toxoid injections, anaemia prophylaxis and supplementary nutrition.

4.2 Lactation

In any area, the number of lactating women will correspond to the number of children below 1 yr. With the birth rate being 30 per thousand and the IMR being 100/1000 live births, the number of children below 1 year will be $30 \times (1 - IMR) = 30 \times (1 - 0.1) = 27$ or there will be 2700 children in a population of 100,000. The number of lactating women who are breast-feeding children will be almost the same i.e 2700 per 100,000 of population. The number of women breast feeding upto 6 months will be half i.e. 1350 or 13-14 in a population of 1000. This number is required to be found for distribution of supplementary nutrition.

NUMBER OF EVENTS EXPECTED IN A YEAR

		In a Population of 1000		100,000
1.	Birth	30		3,000
2.	Still-births	0.45	(at 15/1000 births)	45
3.	Infant Mortality	3	(at 100/1000 births)	300
4.	Toddler Mortality			
	a) 1—3 yr	1.8	(at 30/1000 number in age group 1-3	180
	b) 3—6 yr	1.6	(at 20/1000 of number in age group 3-6)	120
5.	Maternal Mortality	0.09		9
6.	Malnutrition in 0—below 6 yrs			
	a) Moderate	42.4		4250
	b) Severe	45		4500

		In a Population of	
7.	Immunisation	1,000	100,000
		0 — below 1 yr	0 —below 1 yr
	a) BCG	27	2700
	b) DPT 3 doses	27	2700
	c) Polio 3 doses	27	2700
	d) T.T. for pregnant women	30	3000
8.	Pregnant women (in the report)	20	2000
9.	Lactating women (breast-feeding children below 6 months)	13-14	1350

VI. FINANCIAL ASSISTANCE UNDER NEW MONITORING SYSTEM (1985-'86)

With the introduction of new monitoring system from 1st March 1985, the procedure of releasing the grants-in-aid of Chief District Adviser (CDA), District Adviser (DA), Project Adviser (PA) and the Sectoral Adviser (SA) for monitoring and continuing education has been revised and streamlined in States/UTs on the following lines—

1. **Sectoral Meeting :** Medical Officer Incharge of a Sector of PHC (ICDS Sectoral Adviser) will be paid an honorarium of Rs. 20/- for each month, for sectoral monitoring and continuing education. AWWs will draw their TA and DA from CDPO.

2. **PHC level Meeting :** The Medical Officer-in-charge PHC (Project Adviser) will be paid Rs. 25/- as an honorarium for the sectoral meeting for himself and Rs. 25/- as contingency expenses *including clerical assistance for compiling the MMRs.*

3. The district Adviser : He will be paid Rs. 30/- for each project level continuing education and monitoring meeting with a maximum of Rs. 90/- if he takes up three project level meetings. He will also be paid Rs. 10/- per month for postage and contingency.

4. The Chief District Adviser : He will be paid Rs. 50/- for monthly continuing education and monitoring meeting and Rs. 25/- for postage and contingency.

The PHC level and the district level meetings of ICDS will be held on the same date and time as the routine health meetings, therefore no TA and DA will be required separately.

FINANCIAL ASSISTANCE :

1. DISTRIBUTION OF QUARTERLY GRANT

Distributed by	*Functionary*
●Central Cell	(1) State Coordinator (SC) (2) Senior Adviser (Sr. A) (3) O/I Data Analysis Cell (ODA) (4) Consultants
●Central Cell (or) State Disbursing Officer	Chief District Adviser (CDA)
●Central Cell (or) State Disbursing Officer	District Adviser (DA)
●District Adviser	(1) Project Adviser (PA) (2) Sectoral Adviser (SA)

1.1 The Central Cell at the All India Institute of Medical Sciences, New Delhi will release the grant-in-aid *in advance* to State Disbursing Officer, SC, Sr.A, ODA and Consultant for a period of 3 months in 4 instalments in a year.

1.2 The Disbursing Officer of the State/UT will release the grant in advance for 3 months to Chief District Advisers and District Advisers. The grant for the District Advisers will include the grant for Project Advisers (MO I/C PHC) and the Sectoral Advisers (Sectoral Medical Officers) in the PHCs under respective District Advisers. If Chief District Adviser is also having the function of District Adviser he will get the grant on same pattern as for District Adviser.

1.3 The District Adviser at the monthly PHC level meeting will make the payment to the Project Advisers (MO I/C PHC) and the Sectoral Advisers in the PHCs *for the month under review only.*

1.4 The grant to the Chief District Adviser and District Adviser for the next quarter will be released after receiving

expenditure statement of the previous quarter. It will be therefore, absolutely necessary that either at the quarterly meeting or earlier, the CDA and DA should submit their expenditure statements to the Disbursing Officer and Central Cell **within the specified time.**

1.5 The project level and the district level ICDS meetings will be held along with routine health functionaries meetings. Therefore no TA and DA will be required separately for the ICDS meetings. This is extremely important, to be followed by all concerned to save time of the officers and money meant for services to the children.

2. SUBMISSION OF QUARTERLY EXPENDITURE STATEMENTS :

Functionary	*Form*	*To be Submitted to (No. of copies)*	*Schedule for despatch*
●**District Adviser**	Form 'A'	Disbursing Officer (2) Central Cell (1)	Within 15 days of the month, following the quarter
●**Chief District Adviser**	Form 'B'	Disbursing Officer (2) Central Cell (1)	Within 15 days of the month, following the quarter
●**Disbursing Officer**	Form 'C'	Central Cell (2)* State Co-ordinator (1)	Within 30 days of the month, following the quarter

Note *One copy of Form 'C' should be sent along with a copy of Form 'A' and Form 'B'.

2.1 The **District Adviser** would make the monthly payment at the PHC level meeting to the Project Advisers (MO I/C PHC) and Sectoral Advisers (Sectoral Medical Officers)

and will prepare a quarterly expenditure statement on form 'A' (Format 8). The Form 'A' ' includes the details of the expenditure incurred by the District Adviser himself as well as by the Project Advisers and the Sectoral Advisers in the PHCs under him. He will despatch or hand over two copies of Form 'A' to the Disbursing Officer of the State/UT and send one copy **to the Central Cell by 15th of the month following the quarter** e.g. Form 'A' for the quarter Jan-Mar should be despatched latest by 15th April),

2.2 **The Chief District Adviser (CDA)** will prepare an expenditure statement of every quarter on Form 'B' (Format 9) to include the expenditure incurred by him and submit two copies to the Disbursing Officer of the State/UT and **one copy to the Central Cell by 15th of the month following the quarter.**

If CDA is keeping a Project under his charge, he would furnish the details of amounts given to Project Advisers and Sectoral Advisers in the same pattern as given in Form 'A'.

2.3 **The Disbursing Officer of State/UT** at the end of every quarter receives two copies of Form 'A' from the District Adviser and two copies of Form 'B' from the Chief District Adviser. Using the details in Form 'A' and Form 'B' the Disburing Officer would prepare a consolidated quarterly expenditure statement of the State/UT in form 'C' (,(Format 10). He will despatch two copies of Form 'C' to the **Central Cell** (along-with one copy of Form 'A' and Form 'B') and **one copy to the State Coordinotor latest by the last day of the month following the quarter** (e.g., Form 'C' for the quarter Jan-March should be despatched latest by 30 April).

VII. CONTINUING EDUCATION, THE PRESENT STRATEGY

Continuing education of various levels of functionaries is one of the important on-going activities of Integrated Child Development Services Scheme. The continuous advances made in the field of health and nutrition call for regular monthly continuing education programme. This will help in greater understanding of newer problems and will fill gaps in the knowledge and thus improving the quality of services.

1. THE STRATEGY

There are three levels of continuing education in each ICDS project. The district level continuing education is undertaken by the Chief District Adviser. At the PHC level continuing education of various levels of functionaries is being done along with the monthly review meetings by District Adviser.

The continuing education at peripheral level is provided by regular interaction and frequent exchange of information between the Anganwadi Worker and the Auxiliary Nurse Midwife, when they meet each other for various health programmes, such as, immunisation, health check-ups, distribution of iron & folic acid and vitamin A supplements, home visits, health and nutrition education, monthly monitoring report preparation etc. The ANM and AWW would look critically at the health and nutrition status of their areas and initiate ways and means of improving them. This also provides an opportunity for helping each other and for clarifying problems which need to be brought to the notice of the Medical Officer at the sectoral level for further clarification. Although there are no specific guidelines regarding the number of contacts between an ANM and AWW in a month, it is desirable to have regular informal contacts at least 4 times a month (once in a week). At the Sectoral level continuing education is done by Sectoral Medical Officer.

2. SUGGESTED TOPICS FOR CONTINUING EDUCATION

2.1 Sectoral Level

1. Objectives and goals of ICDS
2. Organisation and administrative set up in ICDS project
3. Enlistment of beneficiaries
4. Health check-up
5. Health and Nutrition Components of ICDS
6. Health staff in ICDS project and their co-ordination
7. Antenatal check-up and care of pregnant women
8. High risk approach
9. Intra-natal care and child birth
10. Breast feeding—the advantages
11. Monitoring of the child's nutritional status using weight, mid upper arm circumference and growth charts
12. Immunisation schedule for children and pregnant women
13. Diarrhoea and Oral Rehydration Therapy
14. Medicine kits with Anganwadi workers and treatment of minor ailments
15. Weaning foods
16. Nutritional deficiences—Anaemia, vitamin A deficiency, Goitre, Protein Energy Malnutrition
17. Nutrition and Health Education
18. Supplementary Nutrition for children, pregnant women and lactating mothers
19. Therapeutic Nutrition for severely malnourished children
20. Early detection and prevention of childhood disabilities
21. Drinking water and environmental sanitation
22. Assessment of the health and nutrition status through monitoring reports

23. Infant and Toddler mortality
24. Home visits and their importance

2.2 PHC Level

In addition to above topics, the following are suggested topics for the District Advisor—

1. Method of Reveiwing Monitoring at sectoral level
2. Growth and development of children
3. Immunisation schedule—Importance of cold chain, proper enlistment of beneficiaries and immunization activities, reporting under EPI
4. Health check-up, referral system from AW centre onwards
5. Inter-sectoral coordination between departments/agencies
6. Community involvement in ICDS
7. Continuing Education, its need and importance
8. Field visits and their importance
9. Mothercraft
10. Health programmes implemented through PHC.
11. Supportive supervision of AWW by health workers

2.3 District Level

In addition to the topics suggested for sectoral and PHC level meeting for continuing Education, the following are other topics with emphasis on the administration and management which may be included at the district level—

1. Co-ordination with social welfare or nodal department functionaries
2. Orientation and training courses for Medical Officers, their need and importance
3. Mechanics of release of supplies, grants, vaccines etc.
4. Inter-sectoral and inter-departmental co-ordination of ICDS with MCH, EPI and family welfare departments and other agencies

5. Assistance to consultants for survey and evaluation studies.
6. Discussions on data from evaluation/research studies
7. Review of monthly monitoring reports
8. Discussion on decisions and proceedings of state quarterly meetings
9. Any specific health and nutrition problems in ICDS projects of the district
10. Role of District Level Seminars
11. Role of community participation

VIII. SYLLABUS IN CONTINUING EDUCATION

A. *SERVICES TO CHILDREN*

1. HEALTH CHECK-UP :

The beneficiaries are children in age group 0 to below 6 years, Health check-up should be carried out by the Medical Officer, LHVs and ANMs with the help of Anganwadi Worker.

Children should be examined at least once in every 1-3 months. The objective is to detect diseases, evidence of malnutrition, infection, at risk cases etc.

1.1 'At risk' children

1.1.1. Identification

"At risk children are those who fall under one or more of the following categories :

1. Weight below 50% of the reference standard,
2. Difficulties in breast feeding and introduction of bottle feeding before six months of life, or delay in giving supplementary weaning foods,
3. Failure to gain weight in three successive months.
4. Birth weight of less than 2.5 kg.
5. Twin Births,
6. History of death of two or more siblings below the age of 12 months.
7. Death of either or both parents.

8. Severe acute infection like measles or whooping cough,
9. Birth order 4 or more,
10. Spacing of children is less than 2 years,
11. Only child after a long married life,
12. Upper mid-arm circumference less than 13.5 cms (for age-group 1—4 +).

1.1.2. Management of "At risk children

(i) Enlist them in a special care register.

(ii) Make their weight charts carefully and take weight every month.

(iii) Show these children to ANM/LHV/doctor at earliest and take their help for the treatment.

(iv) Make home visits regularly to their families for necessary instructions.

(v) Give "therapeutic" nutrition and provide special care.

(vi) Emphasize to the mothers that your child needs extra-food.

2. ASSESSMENT OF AGE

First ask for any documentary evidence such as records of AWW, ANM, maternity home, horoscope or birth certificate of the child. If it is not available, proceed to obtain the following information for assessment of age :

Year : Events such as floods, famine, election, new road, electricity connection etc.

Events in the family such as death, birth, marriage and other ceremonies, in the past.

Month : Seasons for planting, harvest, festivals, *Desi* months in the year under reference.

Date : Phases of moon.

The above mentioned method should be able to provide estimation of the age, with ± one month approximation.

3. WEIGHING OF CHILDREN

Ideally, every child under five years of age should be weighed once a month. All children under the age of 3 should be weighed every month. Children over the age of 3 with an upper mid-arm circumference under 13.5 cms. (in the red or yellow zone of the tricoloured strip used to measure the upper mid-arm circumference) should also be weighed every month. The weight should be recorded on the growth chart each time the child is weighed.

3.1 Method of Weighing

3.1.1. Salter Weighing Machine

1. The scale should be suspended freely from a hook and should not rest against a wall.
2. The scale should be at eye level so that the weight can be read accurately and easily.
3. Adjust the scale to zero before each weight is taken.
4. Take the measurement with minimum of clothing and without shoes.
5. Read the weight from a distance of one foot with the eyes vertically at level of the dial.
6. Take the reading to the nearest marking. In case the weight coincides with a division on the dial, read the exact weight, but in case the weight is between the two divisions, then note and record in fractions of 100 g approximately.
7. Always take two readings. If the two readings do not agree, take the average of the two.
8. Record the weight clearly in the appropriate columns in the register/card.
9. Check the accuracy of the weighing scale every week with standard weights.

Some of the new projects are now being supplied bar balance. Follow appropriate instructions for use of the same.

The most important fact about a healthy child is that he/she should gain weight at every weighment done at a monthly interval and his growth curve should be above first line of growth chart.

The weight-for-age graph, (growth chart) has 'weights' marked on the vertical line and age in 'months' on the horizontal line.

The growth chart in ICDS has four curves to indicate nutritional status of the child.

3.1.2 Plotting on Growth Chart

1. It is essential to get the correct age of the child in 'months' before the child is weighed and his/her weight plotted in the chart. The age/date of birth should be written in block letters in the space provided in the chart.
2. The child is weighed and the dot is put on the graph opposite the place for his age in months and weight.
3. If the child is weighed early in the month, the dot is put close to the left edge of the square. And, if the weight is taken late in the month, the dot is put close to the right edge. The dot is put half way of the square, if thc child is weighed in the middle of the month.
4. If the child weighs an exact number of kilograms, the dot is put on the line for the whole kilogram. If a child's weight is above a whole kilo, the dot is put just above the whole kilo line, and if it is just below a whole kilo, it is put just below whole kilo line.
5. The dots put after weighment are joined by a line which should climb up as the child grows older and heavier. The line of dots that a child's weight makes on the card is called his/her **growth curve.**

3.2 Mid Upper Arm Circumference

In situations where facilities for weighing a child are not available, measusement of arm circumference with the help of

a tricolour tape—each colour representing a fixed range of measurement to classify the child as normal, mildly malnourished and moderate to severely malnourished—could be used. (Red colour implies moderate to severe malnutrition, green indicates normal nutritional status and yellow colour indicates mild malnutrition). All children between 1 year to below 5 years should be measured (but not below one or above five years).

Arm circumference includes bone, fat and muscle which form the body's protein and energy reserves, they are reduced if the body does not absorb or take in enough food.

Arm circumference increases with age, but from the first to fifth birthday it does not change much. At this time the body fat is gradually replaced by muscle. Thus, by using this tape with this age group, we do not need to know the exact age of the child in order to know the nutritional status.

3.2.1. Method

- Only left Arm should be used for measurement.
- First make sure that the child is more than one and less than five years of age.
- Let the child's arm hang loosely by its side. Place the tape round the middle of the Upper Arm.
- Note whether the black line (beginning) comes in Green, Yellow or Red colour.
  * If black line is in the green, the child is well nourished
  * If black line is in the yellow, the child is mildly malnourished
  * If black line is in the red, the child is severely malnourished

  This is an age independent, simple and easy method of detecting malnutrition.

4. BREAST FEEDING

Breast milk is sterile, economic, nutritious and specific food for infants. It also has anti-infective properties. The child

should be put to breast and encouraged to suck within an hour of delivery. The initial breast milk is called *colostrum*. It is not harmful as believed by some. On the contrary it is rich in antibodies, hence it should be fed and not rejected. Only small quantity of milk is produced in the first few days. Sucking helps increasing the milk quantity. It also helps the infant's digestive tract by removing meconium (the first stools of the baby).

The quality of milk is always good regardless of the mother's nutritional status. The quantity of breast-miik secreted does not depend upon breast's size. The quantity is usually sufficient to meet the requirements of a child till 4 months of age. Thereafter it is important to introduce supplementary feeding in addition to breast feeding. The mother should be encouraged to breast-feed the child as long as possible.

The duration of a feed is not important. Let the baby suck until it releases the breast spontaneously. It is safe to feed 8 – 10 times a day and even more frequently, if the baby so demands.

Usually in a mother who is breast-feeding, menstruation is delayed and so also the ovulation which helps in spacing of children.

Participants should be taught regarding cracked/flat nipples, breast-feeding during illness of mother/child, insufficient breast milk due to psychological or other reasons, to make subject more comprehensive for purposes of training.

Discourage introduction of top feeds too early in childhood and use of bottle feeds or formula feeding.

5. WEANING FOOD

The breast milk alone is not sufficient to meet the caloric and other nutrient requirements of a child beyond 4-5 months of age. At this age, it becomes necessary to introduce semi-solid foods in addition to the breast milk in child's diet. The breast milk should continue to be the important part of the baby's diet. Items which may be included as weaning foods are roasted and cooked cereals, cooked dhal, ripe bananas, fruits, boiled and mashed potatoes, soft cooked rice, etc.

One weaning food may be tried at a time in small quantities. The quantity may be increased slowly over a period of time. As the child develops a liking for one food, additional weaning foods may be added. **Encourage the use of cheap, locally available weaning foods from the family pot.**

6. IMMUNIZATION

NATIONAL IMMUNIZATION SCHEDULE

To whom	*When*	*Vaccine*	*No.*	*Route*
WOMEN	Pregnancy	TT	2*	Intramuscular
INFANTS	6wks-12 months	] DPT	3	Intra-muscular
		] Polio	3	Oral
	Birth to 12 months	BCG	1	Intra dermal
	9 to 15 months	Measles	1	Sub-cutaneous
	18 to 24 months	] DPT	1**	Intra-muscular
		] OPV	1**	Oral
CHILDREN	5 years	DT	2*	Intramuscular
	5 years	Typhoid	2	Subcutaneous
	10 years	TT	2*	Intramuscular
	16 years	TT	2*	Intramuscular

* give one dose if vaccinated previously.

** booster dose

Note :

— Interval between doses should not be less than one month.

— the dose of all vaccines is 0.5 ml. except BCG which is 0.1 ml. Polio vaccine is given by mouth in 2 drops. Check the label of the vial before use.

The aim of UIP is total coverage of children upto age of 12 months. Older children may be given vaccines on demand.

The ages indicated for the various immunizations are considered, the optimum. However, if there is any delay in starting the first dose, the periods may be adjusted accordingly. It should be the aim that a child before reaching one year of age should have received one dose of BCG, three doses of DPT and three doses of Polio. The BCG, DPT and polio vaccines can be given at the same time. The minimum interval between consecu-

tive doses of DPT and Polio vaccine should be one month. Children below 2 years without BCG scar should be given the BCG vaccination. Infants who have missed DPT and Polio vaccines by the first birthday should be given 3 doses of DPT and 3 doses of Polio by two years of age. Children over five years who have not received DPT should be given two doses of DT at an interval of one to two months.

In case of children of 5-6 years (school entry), one dose of DT as a booster will be sufficient if the child has received DPT or DT earlier. Otherwise two doses of DT at an interval of one to two months are to be given.

The participants must be explained the advantages and precautions for each of the immunisations.

7. GROWTH and DEVELOPMENT

Growth is defined as an increase in the physical size of the body. Development is defined as increase in skills and functions. Growth and Development include physical, intellectual, emotional and social development. Growth is a continuous process throughout the childhood and has a range of normal pattern. Various anthropometric measurements of the body can be used to determine the growth. However, in community programmes, recording of body weight has been proved to be the best method for assessing the physical growth.

7.1 Physical Growth

The parameters of physical growth in children from the age of 6 months to 6 years are given in the table below, but the figures are rounded up. For convenience weight and hight standards for both sexes are being combined.

Age	Ht. in cm.	Wt. in Kg.
Birth	48	2.8
6 Months	63	6.0
1 year	71	8.0
2 years	83	10.0

3 years	91	12.0
4 years	98	13.0
5 years	104	15.0
6 years	110	17.0

7.2 Development

Development of the child is a continuous process and can be assessed by observing the child for develomental milestones. Some of the identifiable stages of development are reached at the ages indicated below :

- Holds the head up and gives a social smile—2 months
- Extends hands, catches objects and brings them to the mouth-4 months
- Sits unsupported-6-8 months
- Crawls and responds to name-8-9 months
- Stands unsupported, repeats words, walks with support-10-12 months
- Walks unsupported, talks sentences of 2-3 words-12-13months

7.3 Monitoring of Growth and Development

(a) The growth and development of the children in ICDS scheme is monitored by periodic recording of their weight for age.

(b) The following categories of children are weighed once a month

i) all children between 0-3 years of age.

ii) All children in Grade III and IV malnutrition till the child has reached above 80% of the expected weight for age.

iii) Children having illness of any type for more than 5 days in a month.

(c) Children between 3 years to below 6 years of age will be weighed once in 3 months.

(d) Enter the weight of the child on the growth chart accurately.

(e) If the child falls in the category of Grade III/IV malnutrition enter his/her name in "at risk" children list and inform the supervisor/ANM/LHV.

(f) Study regularly the growth chart of each child. The direction of growth curve is more important than the weight at one particular period. If the curve remains flat indicating no weight gain for 3 successive weighings or there is downwards dip, it should be brought to the notice of the supervisors.

8. MALNUTRITION

Definition : It is defined as a pathological state resulting from a relative or absolute deficiency of one or more essential nutrients—proteins, minerals, vitamins and energy.

Malnutrition results from interaction of several factors. Ignorance, illiteracy, and poverty leads to inadequate feeding. The traditional beliefs, taboos, food fads, customs and infection are the other major contributing factors to malnutrition.

Malnutrition can be due to specific vitamin/mineral deficiencies. The deficiency of vitamin A in particular, leads to grave complications.

8.1 Protein Energy Malnutrition (PEM)

The PEM comprises a variety of very closely inter-related syndromes described below.

8.1.1. Kwashiorkor

It is probably the result of consumption of low protein diet providing just enough energy to satisfy the needs of the child and is usually seen in children aged 1-4 years.

Diagnostic Criteria of Kwashiorkor

(i) Always present—

(a) pitting oedema

(b) failure to thrive or gain weight.

(ii) Usually present—

(a) changes in the hair-brown, sparse, easily pluckable

(b) disinclination to play,

(c) loss of appetite, and

(d) diarrhoea.

8.1.2 Marasmus

It is a clinical form of protein energy malnutrition primarily due to gross deprivation of calories. Usually occurs in the age group 6 months to 5 years.

Always Present—

(a) failure to gain weight,

(b) wasting of muscles

(c) Loss of subcutaneous fat

Usually present—

(a) irritability, and

(b) good appetite.

8.1.3 Marasmic-Kwashiorkor

Children with marasmic—kwashiorkor have mixed clinical features of marasmus and kwashiorkor.

Classification of malnutrition (Based on weight for age of the child)

Percentage of expected weight	grading	position in growth chart.
80—100%	Normal	Above the uppermost line
70—79%	Grade-I	Between lines 1 & 2
60—69%	Grade-II	Between lines 2 & 3
50—59%	Grade-III	Between lines 3 & 4
Less than 50%	Grade-IV	Below line 4

9. VITAMIN A DEFICIENCY

Deficiency of Vitamin A is the most common cause of blindness in children aged 1-5 years. It results from diet deficient in foods containing vitamin A such as milk, milk products and green leafy vegetables. Night blindness is the earliest symptom of the vitamin A deficiency, later conjunctiva becomes dry and wrinkled. Bitot's spots appear on lateral side of cornea.

Xerosis can be treated with 100,000 to 200,000 International units of vitamin A per day for a week orally.

9.1 Prevention of Vitamin A Deficiency

Vitamin A solution is given to all the children in age group of 1-5 years in dosage of 1 teaspoonful (200,000 units) once in 6 months under National Vitamin A Prohylaxis Programme. All the children in age group of 1-5 years should be examined and record of the amount of Vitamin A administered to each child be maintained.

10. ANAEMIA IN CHILDREN

Anaemia in children is mainly due to iron deficiency but folic acid and vitamin B12 deficiencies also play a part. Anaemia can be due to lack of iron in diet or lack of iron absorption from the gut or due to hookworm infestation. Dark green leafy vegetables and cereals are rich in iron. To prevent nutritional anaemia in children, the following drug schedule should be followed—

One tablet of ironand folic acid containing 20 mg of elemental iron (60 mg of ferrous sulphate) and 0.1 mg of folic acid should be given daily for 100 days per year.

11. VITAMIN B COMPLEX DEFICIENCY

Deficiency of Riboflavine manifests as angular stomatitis and cheilosis. Usually, the clinical deficiency signs are those of a combination of lack of vitamin B complex. Hence, all B-complex vitamins should be supplemented, as assigning

deficiency to individual components of vitamin B complex group may be practically difficult.

12. VITAMIN 'D' DEFICIENCY

Vitamin D deficiency results in rickets. There is enlargement at the ends of the long bones, particularly wrists and ankles, rounded projections may be seen in the form of rickety rosary on both sides of chest. Harrison's sulcus may be conspicuous.

13. SUPPLEMENTARY NUTRITION :– Distribution is as follows–

Children	*Energy* (kcal)	*Nutrient Protein*
1. **Severely malnourished** (Grade III & IV)	600	18-20g
2. Moderately malnourished (Grade II)	300	8-10g
3. Enrolled in nonformal pre-school education (May not be malnourished age 3 to below 6 years)	300	8-10
4. **'At risk' children** (0-6 years)	300	8-10

The guidelines given below should be followed to select the beneficiaries for Supplementary Nutrition on the basis of upper mid arm circumference :—

(i) A child having an upper midarm circumference not exceeding 12.5 cms. (i.e. where the upper midarm circumference is in the red zone of the coloured strip) should be identified as severely malnourished and supplied with therapeutic nutrition (easily digestible nutritious food, preferably pulverized) at enhanced rates (i.e. supplementation to the extent of about 600 calories and 18 to 20 grams of protein per child per day) in three to four feeds out of which at least 2 feeds should be given at the anganwadi.

(ii) Children with an upper midarm circumference above 12.5 cms but not exceeding 13.5 cms (i.e. where the upper mid arm circumference is in the yellow zone of the coloured strip), should be identified as moderately malnourished and supplied with nutritional supplementation to the extent of 300 calories and 8 to 10 grams of protein per child per day.

(iii) Children whose upper midarm circumference is more than 13.5 cms. (i.e where the upper mid arm circumference is in the green zone of the colured strip) are not malnourished and do not need nutritional suppelements at the anganwadi.

(iv) Children in the age group of 3 years to below 6 years, who, may not be malnourished. They who are attending the non-formal pre-school activities will not be debarred from supplementary nutrition. but will be given suppelementary nutrition along with malnourisned children.

(v) Anganwadi workers and their helpers will take special care and make all efforts themselves and with the help of village women to ensure that all severely and moderately malnourished children come to the anganwadi daily for nutritional supplements and that all malnourished children in the age group of 3 years and above but below 6 years attend non-formal preschool activities.

(vi) All children below 6 years, identified as severely or moderately malnourished on the basis of upper midarm circumference (i.e. all children whose upper midarm circumference does not exceed 13.5 cms.) should be weighed every month to monitor their growth.

(vii) The upper midarm circumference of all children below 6 years should be measured once in three months and if the upper midarm circumference of any children, who were not earlier enlisted for supplementary nutrition, are found to be in red or yellow zones in the coloured strip (i.e. not exceeding 13.5 cms.), these children should be added to the list of beneficiaries of supplementary nutrition. Selection of children on the basis of upper midarm circumference should be done at the time of initial survey. Subsequentiy, measurement of

upper midarm circumference by coloured strip should be done for all children below 6 years in the month of January, April, July, and October.

(viii) When the weight growth of a child, who has been receiving supplementary nutrition at the anganwadi, shows that the child has acquired normal weight related to his age, the child's parents should be educated that the child no longer needs nutritional supplements at the anganwadi. Educational efforts should be made with the aim that the parents voluntarily withdraw their children, who have acquired normal weight for age, from nutritional supplements at the anganwadi. Such children should however, continue to be given other health and educational services.

(ix) The poorest families in every village have been identified as IRD target families under the Integrated Rural Development Programme. Children below 6 years belonging to these families should be enlisted for supplementary nutrition. Special effffforts should be made to see that these children get all the health, nutritional and educational services at the anganwadis.

Supplementary Nutrition is given to the children, who are registered at anganwadis, to prevent malnutrition and to treat grade II, III and IV malnutrition.

The supplementary feeding aims at providing approximately 300 kilocalories and 10 gms of protein to children and nearly double this amount to pregnant and lactating mothers in addition to their usual food intake at home.

Note :—

Supplementary food is to be prepared and served at the Anganwadi itself so that consumption of the food by the child is supervised. This will prevent wastage of food which is likely, if the child is permitted to take it home.

The AWW should try her best to provide a supplementary food which is tasteful and liked by the children, by selecting the proper type of foods, changing the preparations of food and serving it while it is hot. She should consult the supervisor for guidance.

It has been pointed out that at the time of distributing supplementary nutrition to children and mothers at the anganwadis, some children who are not identified for supplementary nutrition may be present and it would be difficult to deny supplementary nutrition to such children when they are physically present. If any children, who are not enlisted for supplementary nutrition, are actually given supplementary nutrition at the anganwadis, their number should be separately noted. The monthly progress reports of the anganwadi workers as well as the CDPOs should clearly indicate the number of beneficiaries out of the identified list (in accordance with para I above) receiving supplementary nutrition and the number of unlisted beneficiaries receiving supplementary nutrition. At the same time, educational efforts should be continued, with the help of the local leading citizens and women of the village to educate the community that the supplementary nutrition is required to be given only to those children who are identified in accordance with the given criteria and that the people should desist from sending those children, who are not enlisted for supplementary nutrition, to the anganwadis for receiving supplementary nutrition.

14. THERAPEUTIC NUTRITION

(a) Besides medical care all "at risk" children need special attention in terms of their nutrition intake. Children with Grade III and IV malnutrition are given special food which is called therapeutic nutrition.

(b) The food provided as therapeutic nutrition may be different from that for supplementary nutrition. It can be given in semiliquid form, which can be easily Ingested and digested by the child and its preparation should be easy. It aims at providing about 1000 to 1200 kilo calories and about 20 g. of protein per day. The

child may require a minimum of 4 feeds, of which 2 can be given at anganwadi and 2 can be given by the mother at home. The mother must be properly explained about the importance of special care for such a child and necessity of proper feeding at home.

15. DIARRHOEAL DISEASES

Diarrhoea is passing of at least three or more loose or watery stools per day. Frequent passing of normal stool is not diarrhoea. If mucus or blood is also present, then it is known as dysentery. When a child has diarrhoea, he rapidly loses water and salts due to diarrhoea and vomiting.

The stools of a healthy person contain relatively little water but a person with diarrhoea passes water which contains vital salts (Sodium, Potassium and Bicarbonate). The water and salts must be replaced or the child may die.

When a child has diarrhoea, oral rehydration fluid helps in relieving dehydration and also has positive long term effects on nutritional status of the child. Rehydration mixture can be made at home. The oral rehydration packets are also available with PHC/Subcentre and commercially.

Do not withhold the food of the child suffering from diarrhoea. Even though food passes through the digestive tract much more rapidly during diarrhoea, a certain amount of food is still absorbed.

If possible, the child should receive an extra meal a day for the first week after the attack of diarrhoea.

15.1 Diet During Diarrhoea

Do not withhold the food of the child give foods rich in energy such as banana, potatoes, dahi, cereals cooked rice, khichri, dalia, biscuits. Lemon, orange, pineapple, coconut milk etc. may also be given.

15.2 Signs of Dehydration

- Depression of the anterior fontanelle in infants
- Sunken eyes

- Dry mouth
- Rapid, weak pulse
- Loss of elasticity of the skin (retracts slowly)
- Sudden weight loss
- Little or no urine,

15.3 How to prevent Diarrhoea

1. Breastfeed the child as long as possible.
2. *Never* bottle feed the child.
3. Start giving other foods from four months of age.
4. Make sure the child is always eating enough so that his weight goes up every month.
5. Always give clean and hot food, cooked just before eating.
6. Always use clean drinking water.
7. If there is a latrine, use it and keep it clean.
8. If there is no latrine, pass stools far away from the home and the source of drinking water.

15.4 Rehydralon Solution

Ingredients and composition of Oral Rehydration Salt Solution (ORS) are

Ingredients	**Quantity**
Sodium Chloride	3.5 Grams
Sodium Bicarbonate	2.5 Grams
Potassium Chloride	1.5 Grams
Glucose	20.0 Grams
Drinking Water	1 litre

— The solution will not work unless the right amounts are mixed. If too much of salt is used, the solution may be dangerous. If Salt is less, it may be ineffective.

Recently, a plastic spoon is provided in the Medicine Kit of AWWs measuring 0.7 g at one end (for common salt) and 8 g at the other end (for Sugar). This is dissolved in two hundred ml. of water. A glass measuring 200 ml is also provided.

ORS should be used within 12 hours and should never be used after 24 hours. The child should be given one glass of ORS (200 ml) for each stool.

15.4.1. Classification

Diarrhoea is classified according to the severity of the condition as (1) mild (2) moderate and (3) severe.

1. **Mild diarrhoea**—The child passes stool 4-5 times a day; the anterior fontanelle may be slightly depressed, the child's skin looks normal.
2. **Moderate diarrhoea**—5-10 stools are passed, eyes look sunken; anterior fontanelle is depressed; return of skin fold is delayed but child passes urine periodically.
3. **Severe diarrhoea**—More than 10 stools are passed in a day; eyes are deeply sunken, anterior fontanelle is very depressed; return of skinfold is delayed; may not pass urine for 12 hours and pulse is rapid and weak

15.5 Treatment

15.5.1. Mild and moderate diorrhoea

(a) Oral Rehydration Therapy

(b) Usual foods and boiled water 3 to 4 times daily

(c) When no response to the above treatment in 2 days or appearence of any of the signs given below refer the case to M.O.

(i) child has not passed urine for 6 hours

(ii) breathing rate is more than 50 per minute

(iii) hands and feet of the child are cold

(iv) vomiting starts.

15.5.2 Severe diarrhoea

These patients should be referred to a doctor or the hospital as soon as possible.

15.6 Feeding

For babies who are receiving animal milk, it may be advisable to dilute milk with equal amount of boiled water for 3 days. Do not give diluted milk for more than 3 days. Older children may have rice, khitchri, porridge etc. in gradually increasing quantities as the diarrhoea is relieved.

16. MALARIA

Malaria is caused by a parasite transmitted to the child by the mosquito-bite. Malaria is an infection of blood which causes sudden onset of fever with severe chills and rigors (shivering) lasting a few hours, Fever settles down usually with profuse perspiration. The fever returns at regular intervals (36, 48 or 72 hours), depending on the type of malaria. In mixed infections however, there may not be any clear pattern. Malaria is usually accompanied by headache, bodyache and muscle pain.

Malaria, if suspected, can be confirmed by a simple blood test which is done in PHC, the blood smear, which may be prepared in the field by MPW or malaria worker.

Treatment should be started regardless whether the test is possible or result of the blood test is available. Specific therapy for malaria includes treatment with chloroquine as per dosage given below and paracetamol for fever and generalised bodyaches.

Dosage of chloroquine (150 mg. base)

Age	dose
0-1 year	½ tab
1-4 years	1 tab
4-8 years	2 tab

When fever is very high, cold-water sponge-bath should be given, till fever lowers down.

WARNING : Do not give chloroquine tablets on empty stomach as it may cause vomiting

17. WORM INFESTATIONS

17.1 Threadworms

Threadworms live in the large intestine and rectum. During the night worms come out and lay eggs around the anal opening, causing irritation. The worms can be seen in stools as small, thread like white or pink structures about 1 cm long. Self-infection through fingers and finger nails due to improper personal hygiene is common.

17.2 Roundworms

Roundworms are large worms living in the intestinal tract. They may cause diarrhoea, pain in abdomen, obstruction and at times even difficulty in breathing. These worms may be multiple and very long (10 to 16 cms) and may be passed in stools. The eggs may be present in food stuffs, vegetables and water leading to reinfection.

17.3 Hookworms

The young larva of the worm penetrate the bare foot skin and enter the blood circulation, the lungs and finally to the small intestine. The worms lodge themselves in the small intestine with the help of the hooks and suck blood leading to anaemia and malnutrition. The eggs are excreted along with faeces and are lodged in the soil.

17.4 Whipworms

Whipworms live in the large intestine and cause abdominal pain and diarrhoea. Eggs are passed in the faeces. Eating of contaminated food and poor personal hygiene lead to repeated infection.

17.5 Prevention

Proper sanitation, personal hygiene, sewage and waste disposal are important steps to prevent worm infestations. Sewage wastes should be disposed off, away from all habitation. The community needs to be educated to use proper sanitary latrines and avoid defecation in open fields. Drinking

water should be clean. Hands should be washed before and after eating. Finger nails should be cut regularly. Vegetables should washed thoroughly.

17.6 Treatment

One tablet of mebendazole to be taken with water twice daily for 3 consecutive days. The dosage is same for children and adults.

18. FEVER

When the body temperature is more than 37°C, the child's body feels hot, the skin over the face looks red and the child may be irritable.

During fever, it is necessary to uncover the body as much as possible. A child with fever should never be wrapped in clothing and blankets. The child should drink a lot of water. If the fever is very high or temperature more than 39°C, give cold water sponge both.

Paracetamol tablet is given in case of fever as per dosage given below, every 6-8 hours till fever comes down. The medicine should be given with food or milk.

Children	1-3 years	— ¼ tablet
	3-6 years	— ½ tablet
Adults		— 1 or 2 tablets

If malaria is suspected, give chloroquine tablets in addition to paracetamol. When the child has any infection like sore throat or cough, give suphadimidine tablets as per schedule.

In case, there is rigidity of the neck or fever does not come down within 2-3 days of treatment, the patient should be referred to a doctor.

If the child develops convulsions or fever remains continuously high (above 39°C) inspite of cold sponging, medication etc. He should be referred to the nearest medical facility. Feeding should not be stopped during fever.

19. HEADACHE AND BODYACHE

Headache and bodyache are often associated with any type of fever. If headache is severe, check if the child is able to

make neck movements freely. If not, refer to the nearest medical facility.

If the movements of the neck are normal, give paracetamol tablets as per dosage given below 3-4 times a day.

Children	1-3 years	— ½ tablet
	3-6 years	— ¼ tablet
Adults		— 1-2 tablets

If patint does not get relief with the above treatment within 2-3 days, refer to the nearest medical facility.

20. COUGH

Cough is not an illness by itself, but is symptom of some other sickness effecting throat, lungs, and airway tubes in the chest.

When the cough is of recent origin and there is associated sore throat or slight fever, treat the person with sulphadimidine tablets as per dosage below. If cough has been present for a long time, or when blood is also coughed out, refer the person to the nearest medical facility.

Sulphadimidine dose schedule

	Age	1st dose	Subsequently same dose
Children	0-1 year	½ tablet	every 6
	1-3 years	1 tablet	hours for
	3-6 years	1½ tablet	5 days.
			2 tablets
Adults	—	6 tablets	every 6 hours for 5 days

Patient should drink lot of water and if not relieved within 5 days of treatment, refer to the nearest medical facility.

Also, treat the fever by giving paracetamol (details given earlier).

21. SCABIES

Scabies is an infestation of the skin causing itching and lesions that appear all over the body, especially on the skin between fingers, wrists, around the waists and genitals. Lesions are caused by mite which make lesions under the skin.

If one person in the family has scabies, everyone in the family should be treated.

21.1 Treatment

All the effected members of the family should be treated at the same time.

(a) Give a thorough bath with soap and water

(b) Apply 25% benzyl benzoate emulsion for three consecutive days all over the body except the face. Special attention should be paid to the finger webs, axilla, groins, genitals in males and breasts in females. After three days, give bath with soap and water. All the clothes that are taken off, are boiled in water. Bed linen (sheets, pillow covers and mattresses etc.) are exposed to the sun light for a day.

If the skin lesions are infected which are red and have pus, do not give this treatment but refer to medical facility for proper treatment.

Scabies can be better prevented by personal cleanliness, bathing and change of clothes regularly.

22. SORE EYES

Infection of the outermost lining of the eyes which causes redness, burning sensation and at times, pus in one or both eyes. This condition is known as conjunctivitis. There is watering of the eyes. The eyelids often stick together after sleep.

22.1 Treatment

Boil one glass of water with a pinch of salt and then let it cool. Boil a few pieces of cotton swabs in a small bowel separately and let them cool. Ask the person to lie down.

Wash the hands with soap and water. Take the boiled water in a cup and pour gently into the corner o f the eye near the nose. Discard the dirty water. Take a piece of boiled cotton and wipe the eye gently with one stroke, starting from near the nose towards the ear. Do not use the same cotton piece again. Similarly, clean the other eye also.

After this, pull down the lower eyelid of one eye and put in 2-3 drops of 10 percent sulphacetamide eye drops (20% for adults). Repeat this procedure in the other eye also. Instill the drops 3 times a dav.

Note : If rash or itching starts on the face, stop the above treatment and refer to the nearest medical facility.

22.2 Prevention :

Proper hygiene, including regular washing of face, is necessary. Sore eye can spread from one person to another. So do not let a child with sore eye play or sleep with others: use separate towel, wash the hands after touching the sore eyes.

23. STYE

This is swelling on the eyelid near the lashes. Treatment is same as for the sore eyes.

24. XEROPHTHALMIA (VITAMIN 'A' DEFICIENCY)

This disease is very common in pre-school children. At first, the child cannot see well in the dim light as other people can. Later, he develops dry eyes (Xerosis); the white of the eyes loses its shine and begins to wrinkle. Patches of grey/ white soapy plaque's (Bitot's spots) may be present. Further, the xerosis can get worse and may affect the eye portion (cornea) through which the child sees, leading to scarring and blindness.

24.1 Prevention

Breast feed the child as long as possible. After first 6 months, give the child dark green leafy vegetables, fruits, other vegetables and whole milk etc.

Give Vit. 'A' solution (200,000 IU) once in 6 months from the age of 6 months to the 5 years of age.

24.2 Treatment

If the child already has any of the sign and symptom described above, give one dose of Vit. 'A' solution and refer for immediate attention to the Medical Officer.

25. TRACHOMA

Trachoma is a chronic form of conjunctivits (sore eye) that slowly gets worse. There is no obvious redness but watery eyes may be early symptom in the disease. Later, small pinkish grey lumps are formed on inner side of the upper eye lid. If not treated early, it can lead to blindness. It spreads by flies and needs good personal hygiene and care for prevention of this disease.

25.1 Treatment

Wash the eyes with clean boiled and cooled water every day, twice daily. Put tetracycline eye ointment inside the eyes from the corner of the nose to the ear by pulling the lower eyelid downwards, three times a day continuously for 1 month. The child may be taken to the doctor for confirmation and continued treatment.

26. ANAEMIA

A person with anaemia has weak blood. It leads to decreased work capacity, tirendess, breathlessness etc. Anaemia can be detected by the following symptoms :

Pale skin;

Pale insides of eyelids;

Pale gums;

Shiny smooth tongue;

Whitish fingernails;

Weakness and fatigue;

Anaemia occurs in young children and pregnant women more frequently. It can be avoided by taking foods rich in iron. Bajra and ragi have good amount of iron. Green leafy vegetables, especially amaranth, spinach, beans and peas are other sources of iron. Jaggery also has iron. Animal foods are rich in iron. Children and pregnant women should be encouraged to take iron rich foods.

26.1 Prophylactic Treatment

During pregnancy, women should be given iron and folic acid tablets containing 60 mg. of elemental iron and 0.5 mg. of folic acid every day for 100 days.

Children should be given folifer tablets containing 20 mg. of elemental iron and 0.1 mg. of folic acid, every day for 100 days in a year. These tablets are distributed under National Nutritional Anamia proplylaxis programme.

In case of women and children having severe anaemia, refer them to the sub-centre or to the medical officer for appropriate treatment.

27. CUTS, SCRATCHES AND WOUNDS

To treat a cut, scratch or wound, wash the hands with soap and water. Then wash the wound with soap and water or antiseptic solution. Clean out all the dirt from the wound. Lift up and clean the under surface of skin flaps. Never put alcohol or iodine directly into a wound before cleaning. After cleaning, apply 2 percent solution of iodine on the affected part with a cotton swab and leave it to dry.

If necessary, give aspirin or paracetamol for fever, pain and sulphadimidine for infection. To avoid the wound from getting dirty, apply some clean gauze or loose cotton and bandage lightly. The bandage and the cotton should be changed everyday.

If the wound is very large and bleeding, refer to the nearest medical facility. Advise all patients with cuts or wounds

to get a repeat dose of tetanus toxoid injection from the nearest medical facility.

28. BOILS AND ABSCESSES

A boil or an abseess is an infection which forms a small collection of pus under the skin. It is painful and the skin around it becomes red and hot. It can cause swollen lymph nodes in the neck, axilla or groin region. Fever may also be present.

28.1 Treatment

Put hot compresses over the boil several times a day. Let the boil break open by itself. After it breaks, continue applying hot compresses. Allow the pus to drain. Wash the area with antiseptic solution gently and let the skin dry. Never press or squeeze the boil. Apply 2% solution of mercurochrome or gentian violet on the boil or abscess. Give sulphadimidine tablets as per dosage below :

	Age	1st dose	Subsequently same dose
Children	0-1 year	½ tablet	Every six
	1-3 years	1 tablet	hours for
	3-6 years	1½ tablets	5 days.
Adults		6 tablets	2 tablets every six hours for 5 days.

Ask the patient to drink lot of water. Treat the fever, if present. If no relief within 5 days, refer to the nearest medical facility.

29. CARE OF DRUGS

Use of drugs save lives, but they can be dangerous also. One should therefore be very careful in handling them. The under-mentioned precautions must always be observed :

1. When you give a drug to a patient, write its name and dose clearly and instruct the patient or his attendant about its use.

2. Keep the drugs locked safely in a cupboard, so that a child in the AW does not consume them accidentally.

3. Keep the drugs in a separate container so that they do not get mixed.

4. Ascertain the exact strength of each drug when a new stock arrives.

5. Prescribe the drugs given to you, only for the number of days instructed. Keep a record of the drugs and the dose administered.

6. Check the dose of the prescribed drug, every time even if you are sure that you know the dose by memory.

7. If the age of the child is in doubt, use the dose meant for the next lower age group.

8. Give the drugs for the number of days indicated even if the patient looks well. This is essential for complete cure.

9. If the drug given by you produces adverse effects, e.g. skin rash, note down the name of the drug and the reaction on the patient's card and stop the drug immediately and refer to MO.

Every time you prescribe a drug, you must explain to the mother how it will help e g. you can say that aspirin is being given to relieve pain. Tell the mother to give the drugs for the correct duration in the dosages advised. Show the mother, how to give the drug to the child by giving the first dose in the AW. If the patient vomits the drug, repeat the same dose.

Ask the mother to report to you after a specific number of hours or days, so that you may assess whether the child needs any change in the drug. Instruct the mother to keep drugs at places inaccessible to the child, so that he does not take excess of drugs because he likes the taste.

Also instruct mother that the lotions and antiseptics are to be applied to skin only and may be dangerous if ingested or applied to eyes.

B. SERVICE TO THE WOMEN

Women comprise an important section of any population and they have a major role to play in child welfare and child development. Under ICDS, the groups of women who get special attention are :

(i) pregnant women

(ii) lactating mothers (first six months) and

(iii) women in reproductive age group (15-44 years)

The services given to women are;

(a) Supplementary nutrition including folifer tablets to pregnant and lactating women,

(b) Antenatal and postnatal services including tetanus toxoid immunisation and advice on family planning.

(c) Nutrition and Health Education.

1. SUPPLEMENTARY NUTRITION

	Energy (kcal)	Proteins (g)
i. Pregnant women (2nd & 3rd trimester)	500	18-20
ii. Lactating women (first 6 months)	500	18-20

The reason for supplementing the food intake of pregnant and lactating women is to improve the nutritional status of the mother and increase the birth weight of the child yet unborn and also to build up enough body stores so that the mother can breastfeed the baby without compromising her own nutritional needs.

It has been estimated that more than 50 % of Indian women suffer from anaemia during pregnancy. Under the National

Nutritional Anaemia Prophylaxis Programme, pregnant women are to be given folifer tablets containing 60 mg of elemental iron (180 mg of ferrous sulphate) and 0.5 mg of the folic acid everyday for the 100 days during second and third trimester of the pregnancy. Those who are suffering from anaemia may have to be given further iron therapy after determining the severity and cause of anaemia. The following guidelines should be followed for selection of beneficiaries.

Pregnant women and nursing mothers belonging to the families of landless agricultural labourers, marginal farmers (holding not exceeding one hectare), scheduled castes and scheduled tribes and other poor sections of the community (total monthly income of all members of the family not exceeding Rs. 300) should be enlisted for supplementary nutrition. In other cases, guidance of the ANM/Doctor should be sought. In other words, a pregnant women/nursing mother not belonging to above mentioned categories, can be enlisted for supplementary nutrition if the ANM or the Doctor so advises on medical grounds.

Correct identification and enlistment of beneficiaries of supplementary nutrition in each anganwadi area is a very important task. Wherever this work has not yet been correctly carried out, a fresh exercise should be done to complete this work expeditiously Each Child Development Project Officer and the Medical Officers in the PHC should have a clear consolidated picture of all children and mothers, identified and enlisted for supplementary nutrition according to the guidelines given and periodically review whether all the enlisted children and mothers are getting supplementary nutrition or not. Continuous efforts are necessary to ensure that all the identified and enlisted children and mothers are given supplementary nutrition. Continuous and close attention is especially needed for meeting the needs of the severely malnourished children and the children needing hospitalization.

2 ANTENATAL AND POSTNATAL SERVICES

The primary responsibility of providing such services lie with the staff of the Primary Health Centre in rural areas and urban

health centres. The ANM and the LHV render these services directly. Stress should be on early seeking of ante-natal services and regular check-up to detect high risk pregnancies for appropriate referral to provide hospital or domiciliary delivery as the case may be. Anganwadi Workers should enroll the pregnant women so that ANM can ensure wider coverage.

2.1 Identification of "At Risk" Mothers

"AT RISK" mothers are those who fall under one or more of the following categories :-

1. Those whose pre-pregnancy weight is 38 kg. or less
2. Those whose pre-pregnancy weight is 40 kg. or less at 20th week.
3. Or, if contacted late, weight less than that arrived by adding 1 kg. per month, to 40 kg. weight after 20th week of pregnancy
4. Height 145 cms or below
5. Primipara
6. Have twin pregnancies
7. Previous history of still-births, abortions, antepartum and post-partum haemorrhage or eclampsia
8. Previous history of early neonatal deaths
9. History of previous caesarian or forceps deliveries
10. Age above 35 years or below 18 years
11. Suffering from T.B., severe anaemia, heart diseases or diabetes
12. Have conceived after treatment for infertility
13. Have had 4 or more pregnancies

2.2 Ante-natal care

(a) A minimum of 4 physical examinations should be done during pregnancy of which the one must be after 36 week of pregnancy. The number of visits may have to be increased in high risk cases,

(b) Give immunisation with tetanus toxoid as per schedule

(c) Give folifer tablets for anaemia prophylaxis as per schedule.

(d) Appropriate advice regarding diet.

(e) Advise for preparation for the arrival of baby.

2.3 Post-natal care

Two visits must be paid to the mothers within first 10 days of delivery. Specific advice regarding care of the breast, feeding of colostrum and breast-milk should be given. This opportunity should be utilised to motivate the mothers to accept family planning methods

On an average an Indian mother secretes 600 ml. of milk daily, which yields about 400 Kilo calories and 7 g. of protein. Though breast milk is adequate food for the child upto 4 months of age, the mother should be encouraged to breast-feed the baby as long as possible.

3. TETANUS TOXOID

During the first pregnancy, mothers should be given 2 doses of tetanus toxoid immunization at an interval of 6 weeks. The doses should be given between 16-36 weeks. In case of subsequent pregnancies, single booster dose in the second half of pregnancy needs to be given.

4. LACTATION

A lactating women should take extra diet so that the breast milk secretion is adequate. It must be remembered that a malnourished woman probably secretes a smaller volume of milk, especially if she has borne several children. If a mother has very poor diet and she gives her baby nothing except her own milk, the child may stop gaining weight sooner than usual.

Lactation seems to be physiologically well protected, it does not decline with woman's diet. Milk secretion is maintained at the expense of the woman's reserves and only when these

are used up her milk is affected. Secretion of breast milk depends upon age and nutritional status and mental attitude of the mother.

Lactating women should eat dark green leafy vegetables every day. They should also add ghee/oil to the food.

5. POPULATION EDUCATION AND FAMILY WELFARE

It is very important to train all levels of functionaries on the need for a small family norm. Direct information on family planning be given. The health functionaries including the anganwadi workers can play an useful role by laying more emphasis on positive health, child survival and strained resources of large family for family planning education.

Some of the relevant messages are:

(i) Few children means more of everything for each child.

(ii) There should be a gap of at least 3 years between children, to improve the health of the mother and to give undivided attention to the growing child (child spacing).

(iii) Male or female contraception methods, their availability and advantages.

(iv) Adopt permanent methods after 2 childrens viz., sterilization

6. NUTRITIONAL REQUIREMENTS OF MOTHER AND CHILD

Food is the chief source of essential nutrients which the body needs for well-being. Balanced food is indispensable for health at all stages of life and for satisfactory growth during infancy, childhood and adolescence. Food is made of protein, carbohydrate, fat, vitamins and minerals.

Energy value of food is expressed in terms of Kilocalories. Daily energy requirement for children is approximately as follows:

0 – 5 months	120 Kcal kg of body weight
6 – 11 months	100 Kcal/kg of body weight
12 months	1000 Kcal

Thereafter, add 100 Kilocalories for each year of age till six years, to base of 1000 Kilocalories required at the age of 1 year.

Recommended dietary protein allowances for infants and children by ICMR, 1981, are as follows:

0— 5months	2.0 g/kg. of body weight
6—11 months	1.7 g/kg. of body weight
1—3 years	22 g/day
4—6 years	23.4 g/day

6.1 Recommended dietary intake of Nutrients of expectant and lactating mothers

The foetus gains maximum weight during the last trimester of pregnancy. It has been seen that adequate amount of calories taken during last timester of Pregnancy helps to increase the birth weight. Supplementary nutrition should be started in pregnancy and be continued for 6 months after delivery.

Category of Women (Sedentary)	Kcal	Prn (g)	Cal (g)	Iron (mg)	Vit. A (mg)	Thiamine (B_1) (mg)	Vit. C (mg)
1. Non-Pregnant	1900	45	0.5	32	750	1.1	40
2. Pregnant	2200	59	1.0	40	750	1.3	40
3. Lactating	2450	70	1.0	32	1150	1.4	80

Emphasis should be on—cereals, pulses, green vegetables, milk and milk products. Give iron and folic acid tablets. If adequate amounts of protein are taken in the form of pulses and cereals, milk is not necessary.

Commonly available low cost vegetables, pulses and cereals provide adequate amount of energy and protein. Energy and protein content of 100 g. of edible portion of common foods is as follows:

Per 100 g. of edible portion	Energy in Kcal	Protein in g.
Whole wheat flour	341	12.1
Rice	345	6.8
Bengal gram	372	20.8
Soya bean	432	43.2
Groundnut	567	25.3
Milk (cow)	67	3.2
Milk (buffalo)	117	4.3
Mutton	194	18.5
Egg	173	13.3
Potato	97	1.6
Banana	116	1.2

IX. HEALTH AND NUTRITION EDUCATION MESSAGES

1. BETTER CHILD CARE :

1.1 General advice

1. Breast milk is the best milk for your baby.
2. Breast-feed your child as long as possible.
3. Continue to feed your child even when the child or mother is ill.
4. Start feeding your child semi-solid foods like porridge, khitchdi, soft-mashed fruits and vegetables, etc. when he is 4 to 6 months old.
5. Your child can eat only small quantities at a time. Feed your child 5 or 6 times a day.
6. Give plenty of water to the child when he has diarrhoea.
7. All utensils used for cooking and feeding should be kept clean.
8. Keep foods and water covered and protected from dust and flies.
9. Immunization protects your baby from disease. Get your child immunized.
10. Weigh your child every month and watch him grow.
11. Take your child regularly to clinic for health check-up.
12. Have only two children. Space the children at least two or three years apart.

1.2 Breast Feeding

1. Breast-feed the child soon after birth to give him colostrum.

2. Colostrum is rich in nutrients and helps development of immunity in the child.
3. Breast-feed as frequently as the child demands.
4. Continue breast-feeding even when the mother or child is sick or has diarrhoea.
5. Continue breast-feeding as long as possible.
6. Breastmilk is the best natural food for infants.
7. Breastmilk contains the required nutrients in the right proportion.
8. Breastmilk is clean and protects your child from many infectious diseases including diarrhoea.
9. Breastmilk is readily available and requires no special preparation.
10. Breastmilk does not have to be purchased and is economical.
11. Breastmilk is always available at the correct temperature.
12. Prolonged breast-feeding helps in child spacing.
13. Breast-feeding promotes love and security.
14. Breast-feeding helps the mother to reduce excess weight acquired during pregnancy.

1.3 Weaning (introduction of semi-solid foods)

1. In addition to breastmilk, your baby needs additional food from 4 to 6 months onwards.
2. Give your baby semi-solid foods like kheer, khichdi, soft-mashed fruits and vegetables, etc. from 4 to 6 months on-wards in addition to breastmilk.
3. Introduce only one food at a time and give it regularly for a few days until the baby learns to like it.
4. Start with small quantities and gradually increase the quantity.
5. Feed your baby with semi-solid food five to six times a day in addition to breastmilk.
6. No spicy foods should be given to the young baby.

7. If the baby dislikes a particular food, do not force him to eat it. Discontinue or substitute it. You can try it again later.
8. Introduce all new foods cautiously if the baby has frequent bowel upsets.
9. Stop immediately foods that give allergic reactions and consult medical personnel.
10. Do not give your baby food that has been cooked and kept overnight.
11. Serve foods in a separate plate so that you have good idea of the quantity, the baby has eaten.
12. Wash your hands and baby's hands before feeding.
13. Keep clean all the utensils used for cooking and feeding the baby.
14. Keep flies off the food and keep it covered.
15. Always use clean and safe water to drink.

1.4 Immunization

1. Immunize your child and protect him from whooping cough, tetanus, tuberculosis, poliomyelitis, diphtheria and measles.
2. Immunize your child on TIME.
3. Immunization is effective only when all the doses at suggested intervals are given.
4. Consult health functionary/A.W.W. for correct advice on immunization.
5. Immunize pregnant women against tetanus.
6. Immunization services are available free at health centres/ A.W/dispensaries/hospitals, etc.
7. Get the vaccination done only from reliable sources.
8. Motivate your neighbours and friends to get their children immunized.

1.5 Watch your child grow

1. Weigh your child every month.
2. Regular weight gain is good indicator of rate of growth.
3. Use a growth chart to check the child's rate of growth during the first five years of life.
4. Poor growth rate is a reminder to parents and health worker about the need for better child care.

2. CARE OF THE PREGNANT WOMAN

1. A pregnant woman must prepare for the birth of her baby. Good care begins before the baby is born.
2. A pregnant woman should eat more than what she eats normally to nourish herself and the growing baby.
3. A pregnant woman should eat plenty of green leafy vegetables.
4. A pregnant woman should have regular health check-up.
5. A pregnant woman with health complaints should immediately see the doctor.
6. A pregnant woman should be immunized against tetanus to protect herself and her baby.
7. A health centre is a safe and clean place for delivery.
8. A pregnat woman should avoid as far as possible taking drugs during pregnancy and lactation.
9. A pregnant woman should understand all about breast-feeding.

3. SANITATION AND HEALTHY HABITS

3.1 Sanitation

1. A clean home leads to good health and absence of diseases.
2. Water from unprotected areas, if consumed, can lead to diarrhoeal diseases. Always DRINK CLEAN WATER.
3. Boil water if the water is not clean.
4. Protect your source of water.

5. Always collect and store water in a clean container.
6. Cover all food and water to protect it from flies and dirt.
7. Collections of waste water and solid waste gives rise to unpleasant odours, mosquito and fly breeding and attracts rats and dogs.
8. Flies, mosquitoes, dogs, etc, can spread disease.
9. Waste water can be safely disposed off by having a kitchen garden or a soakage pit.
10. Refuse should be disposed off by burying, composting or burning.
11. Sanitary latrine or using a pit and covering it with earth, is a safe and hygienic way of disposol of human excreta.
12. Keep your house and surroundings clean.

3.2 Healthy Habits

1. Be regular in your daily routine.
2. Go to bed early and rise up early.
3. Take bath every day and keep your body clean.
4. Cut your nails short and keep them clean.
5. Brush your teeth every day in the morning as well as in the night after dinner.
6. Always wear clean clothes.
7. Have regular health check-up.
8. Develop regular eating habits.
9. Eat and drink only clean and safe food and water.
10. Wash your hands before eating.
11. Wash your hands after visiting toilet.
12. Keep your surroundings clean and beautiful.

4. COMMON DISEASES

4.1 Diarrhoea management

1. When a child has repeated loose watery stools, he has diarrhoea.

2. Diarrhoea is not a disease but a symptom of many illnesses.
3. Diarrhoea is usually caused by unclean water and food, dirty habits and surroundings.
4. A child with repeated loose stools may develop dehydration.
5. Give the child plenty of fluids to drink. The water he loses must be made up. Coconut water, rice water, light tea can also be given
6. Diarrhoea can be treated succesfully at home.
7. Make the special drink at home using salt and sugar, mix level palm of sugar, one pinch of salt (three finger pinch) in one glass of water (200 ml).
   Give the child one glass of sugar-salt solution after every watery stool.
8. Continue breast-feeding even when the child has diarrhoea.
9. Continue to feed the child as usual. The child needs food to stay strong and to fight diarrhoea.
10. If the child vomits and is not getting better, consult health worker.

4.2 Health of Eyes

4 2.1 General care of eyes

1. Wash your eyes and keep them clean.
2. Keep away from persons with sore eyes.
3. Protect the eyes from dust, dirt, smoke and bright sunlight.
4. Use clean and separate towel or handkerchief.
5. Do not rub the eyes with dirty fingers.
6. Personal cleanliness and hygienic care will protect your eyes and prevent infections.
7. Avoid use of 'kajal' or surma. If used, always use clean and individual applicator.
8. If the eyes appear red, swollen or watery, consult your doctor immediately.

9. Avoid self medication. Get the eyes checked periodically.
10. Protect your eyes from injuries
11. Keep knife, needles, pens, pencils and other articles with sharp edges away from children.
12. Select toys which do not have pointed ends.
13. Games like guli-danda, fire crackers and bow and arrow should be discouraged.
14. Child below six years should not be encouraged to read fine prints. It may strain the eyes.
15. Do not neglect eye strain.
16. Take care that there is enough light while reading.
17. Diseases such as diabetes and syphilis should be effectively treated as early as possible because it can lead to eye complications.

4.2.2 Prevention of Vitamin A deficiency

1. Vitamin A is important to keep your eyes bright and healthy.
2. Vitamin A deficiency is a major cause of blindness amongst children.
3. Children, pregnant women and nursing mothers should eat foods rich in Vitamin A.
4. Yellow and green leafy vegetables such as palak, carrot, etc. are rich in Vitamin A.
5. New born babies should be given colostrum, the yellowish milk which is rich in Vitamin A.
6. Massive doses of Vitamin A by mouth every 6 months can protect the child from blindness.
7. If the eyes look dry and dull or the membrane of the white part of the eye is wrinkled, consult doctor immediately.

4.3 Goitre

1. Goitre is a disease of the thyroid gland characterised by swelling in the neck.

2. Goitre is caused by deficiency of iodine in the diet.
3. Goitre affects people of all ages but it affects the children most.
4. Goitre hinders both physical and mental growth.
5. Goitre in pregnant women can lead to birth of deaf and mute children.
6. Goitre can be prevented by regular use of iodised salt.
7. Iodised salt prevents further increase in size and even reduces the size of early goitre.
8. Iodised salt is available at approximately same price as common salt.
9. Consumption of iodised salt is safe.

4.4 Care of the ears

1. Do not bathe in dirty rivers and ponds.
2. Do not put pins and needles in your ears.
3. Do not expose ears to loud noise.
4. Do not hit on the ear.
5. Do not put hydrogen peroxide in child's ear.
6. Do not neglect cough and cold.
7. Learn the early signs of deafness.

4.5 Malaria

1. Malaria is spread through mosquito bites.
2. Mosquitoes breed in stagnant water.
3. Do not let any water collect in the house, verandah, open yards, garden, lawn, etc. as mosquites can breed in any water collection.
4. Do not keep any empty containers like tins, buckets, bottles, tyres, etc. in the open where water may collect.
5. Do not keep water tanks/drums on the roof of houses uncovered.

6. Do not allow continued presence of water in any place such as tanks, cisterns, air coolers, flower vases, etc. for more than 6 days at a stretch.
7. All water containers such as tanks, cisterns, air coolers, buckets, flower pots, should be emptied and scrubbed dry once a week.
8. Get all leaking taps and hydrants repaired.
9. House drains must be maintained properly repaired and cleaned.
10. Blocked roof gutters should be cleaned specially before rain.
11. To prevent mosquitoes, keep the neighbourhood clean and use mosquito nets.
12. If you suspect malaria or suffer from any fever, go to a Health Centre for a 'blood test'.
13. Start treatment immediately. The treatment and examination of blood for malaria is free.
14. Take tablets as a preventive measure only after consulting the health worker.

4.6 Tuberculosis

1. Tuberculosis is an infectious disease.
2. Tuberculosis is preventable and curable.
3. Tuberculosis is not hereditary.
4. Tuberculosis spreads through sputum and cough.
5. Persistent cough is an important symptom of tuberculosis.
6. Tuberculosis is completely curable with regular and continuous treatment.
7. Facilities for diagnosis and treatment are available at general hospitals and other health clinics.
8. Protect all infants and children from tuberculosis by BCG vaccination.
9. Avoid spitting on the floor. Practice good hygienic habits.

4.7 Leprosy

1. Leprosy is like any other disease.
2. Leprosy is caused by germs. It is neither hereditary nor a curse of the god.
3. Leprosy can occur at any age, in man or woman.
4. Learn to detect leprosy early. Early signs of leprosy are discoloured patch, loss of sensation, tingling sensation in hands and a thickened nerve.
5. Most of the leprosy cases are non-infectious.
6. Leprosy is completely curable with regular treatment.
7. Infectious cases can be made non-infectious by prompt and adequate treatment.
8. Early detection and regular treatment prevent deformities and disabilities.
9. Help to overcome fear, encourage early detection and sustained treatment.
10. Leprosy patients can continue to live at home and do normal work while under regular treatment.
11. Do not isolate leprosy patients. Accept them in the family and in the community.

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—1

AWW's MONTHLY MONITORING REPORT FORM:

1. Reporting Month ..... 2. Year ..... 3. Name of village where AW is located .....
4. S. No. of the AW..... 5. Total population of the AW area .....
6. No. of days supplementary nutrition was distributed at AW... .....
7. No. of malnourished children – (Please tick the method used: – Weighment/Tricolour tape.)
   (i) Grade II or Yellow..... .....
   (ii) Grade III or Red..... .....
   (iii) Grade IV or Red..... .....
8. Diarrhoea
   (a) No. of children who had diarrhoea.....
   (b) No. of mothers advised oral rehydration therapy.....
9. a) Total no. of children in the age group

(i) 0—1 year .....(ii) 1 yr to below 3 years.....
(0—11 months) **(12—35 months)**

(iii) 3 yrs to below 6 years.....(iv) Total 0—6 years.....
(36 to 71 months) **(0 - 71 months)**

b) Whether the following immunizations were carried out in the month (Please tick).

BCG	Yes/No
DPT	Yes/No
Polio	Yes/No
Measles	Yes/No
D.T.	Yes/No
T.T.	Yes/No

10. Birth and Death Data

Name of event	No. in the reporting month	Total no. since last 26th Dec. (cumulative)
i) Live births	.....	.....
ii) Still-births	.....	.....
iii) Deaths in age group 0 to below 1 year	.....	.....
iv) Deaths in age group 1 yr to below 3 years	.....	.....
v) Deaths in age group 3 yrs to below 6 years	.....	.....
vi) Deaths of pregnant women during delivery	.....	.....

11. Total no. of Pregnant Women in the Anganwadi population .....

12. Lactating Women

(a) Total number..... .... (b) Total no. received Mother and Child Welfare pamphlet.....

13. Reviewed by	Date	Signature
i) ANM/MPHWF	.....	.....
ii) Sector M.O./LHV/HA (F)	.....	.....

Note: 1. **Figures for columns 5,7,8,9,10,11,12 be given as on 25th day of the reported month.**

2. The report should be discussed with ANM and LHV and finally submitted to sector M.O. at the **sectoral meeting (between 26th to 30th day of the month under report).**

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—2

Sector Medical Officer's Monthly Report on SECTORAL Monitoring and Continuing Education for the month of 198

1. Name of the PHC..... .....

2. Sector No. I/ II/ III/ IV/ V (Circle around your sector No.)

3. (i) Population of your sector.....

   (ii) Population of the reported AWs in your sector.....

4. Sectoral Meeting held on (date).....at Village (Name) .....

   (This meeting must be held between 26th to 30th of every month)

5. Topic discussed for Continuing Education.....

6. Staff Position (for your sector only)	No. sanctioned	No. in position	No. attended meeting
a) LHV/HA (F)	.....	.....	.....
b) ANMs/MPHWs (F)	.....	.....	.....
c) AWWs			

7. Did MS participate in the meeting (Please tick) Yes/No

8. No. of AWs visited by you during the reference month.. .....

9. Remarks if any .....

.....

.....

.....

Date... .....

Signature.. .....

Name of M.O.....

Note: 1. Reference month **(from 26th of last month to 25th of the month under report)**

2. The report is to be submitted to the Project Adviser (M.O.I/C PHC) **latest by 30th day of the reference month.**

3. All the MMRs received from AWWs in your sector till 30th should be submitted to M.O. I/C PHC along with your Report.

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—3

Monthly Monitoring Report of Project Advisor (MO I/C PHC) for the month of 198
(from 26th of last month to 25th of the month under report)

1. Name of the PHC..... .....
2. a) Name of the ICDS Project.....

   b) Type of project (please tick). (Rural/Tribal/Urban)
3. District.....
4. State.....
5. Total no. of Sectors in the PHC..... Total No. of Sectors Reported.....
6. No. of AWs in the PHC: Sanctioned..... Functioning..... Reported.....
7. Population i) PHC..... ii) Reported AWs (All sectors).....
8. Total no. of sectoral level training courses organised by all the M.Os ....
9. a) Topics discussed.....

   b) No. of participants (All sectors).....

10. Staff Position

	No. sanctioned	No. in position	No. trained
a) Medical Officers	....	.....	.....
b) LHVs or HAs (F)	....	... .	Not applicable
c) ANMs or MPHWs (F)	.....	.....	Not applicable

11. No. of AWs visited by all the MOs for health check-up..... .....

12. No. of AWs where Supplementary Nutrition was distributed

More than 15 days..... less than 15 days . ... 0 days .....

13. Total No. of malnourished children in the reported AWs **(Please tick the method used:- weighment' Tricolor tape).**

i) Grade II (Yellow). ..... ii) Grade III & IV (Red)..... .....(iii) Total... .....

14. Total No. of Children who had diarrhoea .....No. of mothers advised ORT .....

15. Population break-up in 0-6 yrs. Age groups of children as reported by AWWs

(i) 0 to below 1 year (ii) 1yr to below 3 years (iii) 3 yr to below 6 years (iv) Total. 0 to below 6 years

(0—11 months) (12—35 months) (36—71 months) (0—71 months)

16. Immunization performance figures to be filled in from the available information at the PHC (as reported under EPI for children below 1 year).

Total No. immunised in the PHC	BCG	DPT 1st	DPT 2nd	DPT 3rd	Polio 1st	Polio 2nd	Polio 3rd	Measles	Tetanus Toxoid (preg. women) 1st	Tetanus Toxoid (preg. women) 2nd
In the reporting month										
Total since 1st April										

17. Birth and Death data:

Nature of event	No. in the reporting month	Total since last 26th December (Cumulative)
i) Live births	.....	.....
ii) Still-births	.....	.....
iii) Deaths 0 to below 1 yr. (0—11 months)	.....	.....
iv) Deaths in age group 1 yr.to below 3 yrs. (12—35 months)	.....	.....
v) Deaths in age group 3 yrs. to below 6 yrs. (36—71 months)	.....	.....

vi) Total no. of deaths of pregnant women during delivery .....

18. Total no. of pregnant women in the reported Anganwadis.....

19. Lactating women a) Total no. in the reported Anganwadis .....

b) Total no. received mother and child welfare pamphlet.....

20. Supplies position-Tick mark the correct answer

Position	Vit. A	Iron & Folic acid Tablets	Drugs for AWs	Vaccines				
				BCG	DPT	Polio	Measles	TT
Adequate**								
Inadequate								

** Indicate adequacy as per monthly requirement, in reference to total requirement for the target given to PHC.

21. Funds from Social Welfare Department for POL (Please tick) Received/Not received

22. Medicine Kits for AWWs (Please tick) Received/not received

Note: Please fill all the information. **Do not keep any space blank. Write either actual number or 'nil' instead of dash.**

Signature.....

Name.....

PHC.....

Full Address.....

Date.....

Note: 1. **Despatch the Report to Central Cell within eight days after the end of each month.**

2. **Copy of MMR should be sent to the state co-ordinator and Chief District Adviser within eight days after the end of each month.**

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—4

District Adviser's Monthly Monitoring Review Report for the month of 198

1. Name of the district.. .... State..... .....

2. Number of Sanctioned ICDS Projects in the district ....

3. Number of Operational ICDS Projects under your charge ....

4. Number of Project Advisers under your charge..... ....

5. Monthly Monitoring Reports received from the PHCs of Operational ICDS Projects under your charge

Name of ICDS Project	Name of PHC	Date of MMR checked and despatched	Date of PHC Level Meeting and Continuing Education	Topics discussed (Title only)	No. of participants MO. LHV. CDPO MS. Others
i)					
ii)					
iii)					

6. Number of lectures for S.W. functionaries delivered by you during the month .....

7. Quarterly Expenditure Statement sent (Please tick) Yes/no

8. Remarks if any, on coordination with CDPO and on Food quality at AW Centre.....

.....

Signature..... .....

Name (in block letters).....

Full Address..... .....

Date..... .....

Note : 1. The monthly meetings in all ICDS projects under your charge should be completed within 7 days after the end of each month.

2. This MMR be submitted to Central Cell within 11 days, after the end of each month.

3. Copy of MMR should be sent to the State Co-ordinator within 11 days, after the end of each month.

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—5

Chief District Adviser's Monthly Review Report for the month of ....198.....

1. Name of the District..... Population .....State. .. ..

2. Date of District Level Meeting..... .....

3. Number of ICDS Projects in the District a) Sanctioned..... ... ...
   b) Operational ....

4. Number of ICDS health functionaries in the district a) District Advisers.....
   b) Project Advisers..... ....

5. Name of District Adviser	Name of Project	Name of Projects/PHCs under his charge	No. of Project Advisers reports despatched by PAs in the district to central cell
i)	.....	....	....
ii)	.....	.....	.....
iii)	.....	.....	.....
iv)	.....	.....	....

6. Immunization performance in the district (These figures are to be filled from the available information for children below 1 yr under EPI at the District Headquarter.)

(i)	No. immunised in the Distt.	BCG	D. P. T. doses			Polio doses			Measles	TT to Preg. Wom.	
			1st	2nd	3rd	1st	2nd	3rd		1st dose	2nd dose
(ii)	During the month (Since first April) cumulative										

7. ICDS Coordination Committee in the district : Formed/Not formed

If formed, Meeting in the Reported Month : Held/Not held If held Date.....

8. District Level Seminar on ICDS organised : Yes/No If Yes..... a) Date.....

b) No. of health functionaries participated.....

9. No. of participants at the Distt. Level Meeting—

a) District Advisors, No. ..... b) Project Advisors, No. .....

c) CDPOs, No. ..... d) Distt. Social Welfare Officers No.....

e) Others, No. .....

10. Quarterly Expenditure Statement sent Yes/No

11. No. of Lectures taken for Social Welfare functionaries during the month.....

Remarks if any.....

Signature.....

Name (in Block letters).....

Designation.....

Date.....

Full Address.....

Note : 1. The District Level Review Meeting of ICDS should be combined with the routine monthly meeting at the District Headquarter.

2. **This Monthly Review Report be submitted to Central Cell within 21 days after the end of each month.**

3. Copy of MMR should be sent to State coordinator within 21 days, after the end of each month.

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—6

QUARTERLY REPORT OF THE SENIOR ADVISER

1. Name of the Senior Adviser.....State.....

2. Report for the quarter ending 31st March/30th June/30th Sept/31st Dec. 198 **(Please tick)**

3. a) District level meetings attended (Places and dates).....

Name of Distt.	Date	Name of Distt.	Date	Name of Distt.	Date

b) Project level meeting attended (Place and date).....

Distt.	Date	Distt.	Date	Distt.	Date

c) Field visits to PHC with ICDS projects in the quarter (Place and date).....

Distt	Date	Distt.	Date	Distt.	Date

d) If you have attended any other ICDS meetings please give date and place.

4. District Level Seminars (DLS) attended in the quarter—

5. No. of lectures for Social Welfare Functionaries delivered during the reported quarter.....

6. Date when Expenditure statement despatched..... ....

7. Specific recommendations if any.....

Date.....

Signature.....

Name.....

Full Address..... .....

Note . 1. At least one meeting or visit is expected each month

2. A brief report on a), b), and c) above should be sent to Central Cell and State Coordinator.

3. **The quarterly report should be submitted to Central Cell within 30 days, after the end of each Quarter.**

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—7

QUARTERLY REPORT OF THE STATE COORDINATOR

1. Name of the State Coordinator..... 2. State/UT.....

3. Report for the quarter ending : 31st Mar/30th June/30th Sept/31st Oct. 198 (Please tick)

4. Projects Status (At the end of the reporting quarter)

Sector	No. Sanctioned	No. Functioning	No. Allotted for Monitoring
Central	.....	....	....
State	.....	.....	... .
Total	.....	.....	.....

5. a) No. of functionaries in position at the end of the quarter

i) Chief District Advisers (CDAs)..... ..... ii) District Advisers (DAs).....

b) MMRs receipt position (at the end of reporting quarter)

Month in the reporting Quarter	CDAs Reports		DAs Reports		PAs (MO I/C PHC) Reports	
	Expected	Received	Expected	Received	Expected	Received
1st Month						
2nd Month						
3rd Month						
TOTAL						

6. Consultants performance (at the end of reporting quarter)

No. of consultants (At the end of quarter)	No. of Qtly. Repts. Recd.	Orientation & Training			Refresher courses		Birth & Death study		No. of consultants involved in Annual Survey
		No. of Courses held	No. oriented Advs.	MOs. Others	No. held	No. of Parti-cipants	No. of Repts Expe-cted	No. of Repts Received	

7. Quarterly report of Senior Adviser : Received/Not Received.

8. No. of Lecture hours devoted for Social Welfare Functionaries during the quarter by

i) State Co-ordinator ii) Sr. Adviser iii) ODAs

iv) Consultants v) CDAs vi) DAs

9. Quarterly Exp. Statements submitted to the Central Cell by (Please tick)

i) State Coordinator..... ..... ii) Senior Adviser..... iii) ODA.....

iv) Consultants ..... v) Chief District Advisers..... vi) District Advisers..... .....

10. Monitoring Feed-back from Central Cell, received for the month of..... in the quarter

Comments on Action taken by state coordinator

a) Shortfall in MMRs

b) Staff position

c) Sector level training

d) Supplies

e) Vital Statistics

f) Immunisation

11. Specific problems/points (if any) related to above points may be mentioned below

....

.....

12. Paper cuttings/Assembly questions if any on ICDS during the quarter (Please attach copies thereof)

Signature of State Coordinator	Signature of ODA
Name	Name
Date	Date

Note : **The Quarterly report should be submitted to Central Cell within 45 days after the end of each Quarter.**

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—8

Form 'A'

Expenditure statement of District Adviser

For the Quarter ending..... .**for the period from**..... **to** ....

Name of State/U.T. ..... District ....

Expenditure of PHCs

S. No.	Name of the PHC	Name and designation of ICDS Functionary (Please tick) PA/SA	Honorarium (Rs.)	Contingency (Rs.)	Total (Rs.)
1.		(i)			
		(ii)			
		(iii)			
2.					
	TOTAL				

Expenditure of District Adviser for the Quarter ending ..... for the period from ..... to.....

Months	Name of the District Adviser	No. of PHCs visited	Honorarium for contd. Edu.(Rs. 30/- per PHC conference, Max. of Rs. 90/- per month) (Rs)	Contingency (Max. of Rs. 10/- per month) (Rs.)	Total (Rs.)
1st					
2nd					
3rd					
TOTAL					

Total Expenditure Incurred

S.No.	Expenditure incurred by	Honorarium (Rs.)	Contingency (Rs.)	Total (Rs.)
1.	PHCs			
2.	District Advisers			
	TOTAL			

Certified that the expenditure has been incurred for the objectives for which it was sanctioned.

Signature of District Adviser.....

Name.....

Full Address.....

Note : **Please despatch within 15 days after the end of each quarter two copies to Disbursing Officer of the State/UT and one copy to Central Cell, AIIMS, New Delhi.**

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—9

FORM 'B'

EXPENDITURE STATEMENT OF CHIEF DISTRICT ADVISER

For the Quarter ending..... for the period from.....to ... .

Name of State/UT... District.....

Month	Name of the Chief District Adviser	Expenditure of Chief District Adviser. Honorarium for Contd. Edu. (Rs. 50/- per month) (Rs.)	Contigency (Max. of Rs.25/- per month) (Rs.)	Total (Rs.)
1st		....	.....	.....
2nd		....	....	.....
3rd		.....	.....	.....
TOTAL		....	....	....

Certified that the above expenditure has been incurred for the objectives for which it was sanctioned

Signature of Chief Dist. Adviser.....

Name.....

Full Address.....

Note : **Please despatch two copies within 15 days after the end of each quarter to Disbursing Officer of the State/UT and one copy to the Central Cell, AIIMS, New Delhi.**

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—10

FORM 'C'

EXPENDITURE STATEMENT OF DISBURSING OFFICER OF THE STATE/UT

For the Quarter Ending.. .....for the period from .... to .....

Name of State/UT.....

Balance sheet of the State/UT

S. No.	Item	Amount Rs.	P.
1)	Opening Balance at the beginning of the reporting quarter	.....	
2)	Amount received during the reporting quarter	.....	
	TOTAL (of ! & 2) = X		
3)	Expenditure incurred till the end of the reporting quarter		
	i) a) Honorarium to the Accountant	.....	
	b) Contingency (Expenditure incurred by the Disbursing Officer on postage, stationery, etc. maximum of Rs. 25 per quarter)	.....	
	c) Printing of AWWs proformas.	.....	
	(Total No. forms printed for months)		

	Amount Rs.	P.
ii) By District Advisers (Format 8, Form 'A').....		
iii) By Chief District Adviser (Format 9, Form 'B')		
TOTAL (i, ii and iii) = Y		
4. Balance at the end of the reporting quarter (X—Y).....		
5. **Amount required to meet the next quarter expenses**.....		
(after deducting the balance amount with you).....		

Certified that the above expenditure has been incurred for the objectives for which it was sanctioned.

Signature of Disbursing Officer.....

Name.....

Full Address.....

Certificate to be furnished by the Accountant

Certified that I have gone through the accounts and found the same to be correct

Signature of Accountant.....

Name.....

Full Address.....

Note : **Please send two copies within 30 days after the end of each reporting quarter to the Central Cell, AIIMS and one copy to the State Co-ordinator of the State/UT.**

INTEGRATED CHILD DEVELOPMENT SERVICES

Format—11

EXPENDITURE STATEMENT OF CDA

Applicable in the states where Disbursing Officers have not been appointed and grant is being released through Chief Distt. Adviser).

Expenditure statement for the Quarter ending..... .. . for the period from..... . . . to..... ..

Name of State/UT..... ..... Distt..... .....

Table (1) Expenditure of PHCs

S. No.	Name of the PHC	Name & Designation of ICDS functionary	(Please Tick)	Hon. Cont.	Contg.	Total
1.		(i)	PA/SA	Edn.		
		(ii)	PA/SA			
2.		(i)	PA/SA			
		(ii)	PA/SA			
		Total 'A'				

Table (2) Expenditure of Distt. Advisers

Months of the quarter	Name of the Distt. Adviser	No. of PHCs Visited/ conferences attended.	Honorarium* Cont. Edn.	Contg.**	Total
1st					
2nd					
3rd					
		Total 'B'			

*Rs. 30 per PHC visited : maximum of Rs. 90 per month.

**Maximum of Rs. 10 per month.

Table-(3) Expenditure of Chief Distt. Adviser

Months	Name of the CDA	Honorarium* Cont. Edn.	Contingency	Total
1st				
2nd				
3rd				

Honorarium for the period from.. ....to..... .....

Sh..... ...Accountant** at the rate Rs. 20/- per month

Total 'C'

*Honorarium to the CDA is Rs. 50/- per month

**No contingency budget for Accountant

Table (4) Total Expenditure incurred

S. No	Exp. incurred	Honorarium	Contingency	Total
1.	PHC's (Total A)			
2.	Distt. Advisors (Total B)			
3.	Chief Dist. Advisors (Total C)			

Total .....

.....

Certified that above expenditure has been incurred for the objectives for which it was sanctioned.

Signature of Chief Distt. Adviser.....

Name in block letters.....

Full Address..... ....

Certificate to be furnished by the Accountant

i) Opening Balance .....

ii) Grant Received during the quarter .....

iii) Exp. incurred As per Table (4) .....

iv) Balance available .....

v) Funds required for next quarter .....

Certified that I have gone through the accounts maintained by Dr..... Chief District Adviser and found the same correct

Signature of Accountant.....

Name in Block Letters.....

Full Address .....

Appendix I

Copy of the letter No. 3-1-81 CD dated 14th January, 1983

Subject : Health inputs in the ICDS projects.

I am directed to invite attention to this Ministry's letter of even number dated the 31st July, 1982, with which a copy of the Union Ministry of Health and Family Welfare's, letter dated 27-7-1982, addressed to the State Health and Family Welfare Departments, had been forwarded for your information. In the later letter, the Ministry of Health and Family Welfare had directed the State Departments of Heath and Family Welfare to take suitable action for prompt posting of the health staff in the ICDS blocks, especially the Medical Officers, the ANMs and the LHVs as per pattern approved by that Ministry.

Later on, in this context, this Ministry pointed out to the Ministry of Health and Family Welfare the difficulties that had arisen in the opening of additional sub-centres in the new ICDS project areas on account of the prevailing conditions that the earlier backlog vacancies are to be filled first. Thereupon, that Ministry have issued further clarifications to the Health Departments of various States and UTs to the effect that the following order of priority should be observed while opening new sub-centres :—

i) Filling up the vacant posts of ANMs in sub-centres located in Primary Health Centres covered under Areas projects and the ICDS blocks.

ii) Opening of new sub-centres in Primary Health Centres in Area projects and the ICDS blocks.

iii) Filling up of the vacant posts of ANMs in existing sub-centres in other areas.

iv) Establishment new centres in other areas;

A copy of Ministry letter No. P-18012/3/82—RHD dated 7-1-1983 is enclosed for information.

2. As may be observed, the posting of ANMs in vacant sub-centres and the opening of new sub-centres in ICDS blocks an Area Projects are now to be accorded in highest priority by the State Health Departments. It is therefore requested that action may now be expedited to fill in the vacant post ANMs/LHVs in ICDS project areas as well as to open new sub-centres in the ICDS project areas so as to achieve the accepted norms of health set up. The State Health Departments should be approached suitably, under intimation to this Ministry.

Copy of the letter No. P 18012/3/82-RHD dated 7 January 1983 from the Ministry of Health and Family Welfare

To Health Secretaries of all States and UnionTerritories.

Subject : Family Welfare Programme--Setting up of additional Sub-Centres to achieve the norm of one Sub-Centre for 5000 rural population in non-tribal areas and one for 3000 rural population in tribal and hilly areas during Sixth Five Year Plan under the Family Welfare Programme, centrally sponsored plan scheme.

In partial modification of this Ministry's letters No. M 12012/2/81-FWB dt. 8-9-81 and No. P-18012/3/82-RHD dated the 14th May, 1982 on the subject mentioned above it has been decided that the following order of priority may please be observed while opening new sub-centres.

1. Filling up the vacant posts of A.N.Ms. in Sub-Centres located in P. H. Cs. covered under Area projects and I. C. D. S. blocks.

2. Opening new sub-centres in PHCs in Area Projects and ICDS block.

3. Filling the vacant posts of ANMs in existing sub-centres in other areas.

4. Establishing new sub-centres in other areas The new Sub-Centres should be established after recruiting additional ANMs and should in no case be established by transferring ANMs from the existing Centres.

Appendix II

Copy of the letter No. 12-54/82-CD dated 28 Feb., '83 from the Ministry of Social Welfare, Govt of India

Subject : Involvement of Medical Colleges in Implementation of ICDS Programme.

The rules of the Medical Council of India stipulate that the Prevention and Social Medicine and Paediatrics Departments of each medical college would have field practice area, which would vary from one to three blocks in number. Further, Medical Colleges involved with the project of the Union Health Ministry for Reorientation of Medical Education have three blocks each, while other Medical Colleges have one block each for field practice.

2. It has now been decided, with the concurrence of the Ministry of Health and Family Welfare, that a Medical College can be entrusted with the implementation of the ICDS Programme in any particular Project, if that project is located in the field practice area of the Medical College concerned.

3. It is therefore requested that the State Government/ UTs Administration may please consider entrusting the implementation of at least one ICDS project to each medical college, such project being located in the field practice area of the medical college.

Appendix III

Copy of the letter No. F. 4-2/83-AT dated 23 April, '83 from the Ministry of Social Welfare, Govt. of India

Subject : Orientation Courses for Medical Officers and Advisers of ICDS area—Facility also for Health Teachers of the Anganwadi Workers' Training Centres.

Health teachers for the Anganwadi workers training centres are mostly private practitioners who have not been given ICDS orientation. They need to be oriented to the ICDS scheme so that they can provide the right kind of health training to the Anganwadi workers. The All India Institute of Medical Sciences, New Delhi has also felt the necessity of such a step.

2. It has been decided that whenever Orientation Courses of Medical Officers and Advisers are arranged by the training consultants, the Anganwadi training centres should take advantage of such Orientation Courses by deputing their part time/full time health instructors to attend these courses. You are, therefore, requested to contact the training consultants for deputing your health instructors for the Orientation Courses.

3. It is also clarified that T.A./D. A. to health instructors for attending such Courses will be paid by the training consultants.

Copy of the letter No. 15-4/83-CD dated 21 Nov., '83 from the Ministry of Social Welfare, Govt. of India

Subject : Number of Anganwadis in Integrated Child Development Scheme Projects—total coverage of the project area.

I am directed to refer to letter No. 3-1/75-CD dated 29 November 1975 from this Ministry on the above mentioned subject and reiterate that the general model of the Integrated Child Development Scheme which envisages 50 Anganwadis in a tribal project and 100 Anganwadis in a rural/urban project, has to be adapted to the needs of each Integrated Child Development Scheme project area depending on its demographic and other features.

2. During field visits, it has been noted that there are projects in which the entire population of children and mothers are not being covered by the package of services provided under the Scheme. It is reiterated that State Governments should ensure that every project area is devided into Anganwadi areas so that no area is left out. The following action is suggested in this regard :

(a) Several blocks which have been selected for the Integrated Child Development Scheme project have a population of more than one lakh. The number of Anganwadis in those projects should, therefore be increased so as to cover the entire population.

(b) In hilly or desert areas, which may be sparsely populated, villages may be very small or divided into small hamlets. In such cases an Anganwadi may be set up in every small village or hamlet having a population of 300 or more.

(c) Very small villages/hamlets (with a population less than 300) may be covered by the adjoining Anganwadi. In these villages/hamlets, weekly or fortnightly visit by the Anganwadi Worker in whose area such a village/hamlet is located, can be feasible. For supplementary nutrition some local family or voluntary worker should be entrusted with the responsibility of storing, cooking and distributing food to each beneficiary every day. For health checkups and immunisation, advance intimation should be given to such small hamlets or villages about the days of visit of the para-medical workers to the Anganwadi so that children and mothers can come to the Anganwadi on the appointed date.

(d) In some places where population is very scattered (for example, clusters of 3-4 huts at long distances) especially in hilly areas, a take home ration may be the only feasible alternative.

3. In nutshell, arrangements in every Integrated Child Development Scheme project should be made in such a manner as to ensure that all children, pregnant women, and nursing mothers are covered under the programme and no child is deprived of the facilities provided under the Integrated Child Development Scheme programme. The number of Anganwadis in each project area may be worked out by the concerned field officer to whom the State Government may entrust this responsibility and information sent to this Ministry. Number of Mukhyasevikas will also be increased proportionately. Additional funds will be made available by this Ministry in order to cover expenditure on additional anganwadis and supervisors in accordance with these guidelines.

Appendix V

Copy of the letter No. 15-1/83-CD dated 18 August, '84 from the Ministry of Social Welfare, Govt. of India

Subject : Integrated Child Development Service—Supply of medicine kits for use in.

The Integrated Child Development Services scheme provides for supply of certain simple medicines to the beneficiaries through Anganwadi Centres. Under the scheme, a provision of Rs. 300/-has been made for this purpose.

2. During the course of visits to Anganwadis, it has been observed that, quite often, the requisite supply of medicines is either not available at all or is available for short periods only or in respect of a few medicines only. Therefore, it has been decided that Medicine kits will be procured centrally and directly supplied by this Ministry through the approved manufacturers.For 1984-85, the medicine kits will be supplied at the District Level by the IDPL. The District Level Officers will arrange supply of these kits to the Child Development Project Officers, concerned, who will distribute the same to the anganwadi centres. Expenditure on storage and transportation of kits from District to Project can be met from central ICDS grants. A note indicating the composition of the kit and its use is enclosed. Printed copy of this note, in the official regional language of your State Union Territory will be included in each kit supplied in your State Union Territory by the IDPL.

3. The supply of kits are likely to commence in about a month. The State Governments are therefore requested

not to purchase any further medicines from ICDS budget. The medicines already purchased or for which firm orders already have been placed, may however, be utilised Necessary instructions in this regard may kindly be issued to the Child Development Project Officers.

4. The proposed list of consignees in your State at District level is enclosed. In case the State Government desires a change therein, this Ministry may be advised suitably immediately latest by 10 September 1984. The designated consignees may be advised to make necessary arrangements for the receipt of supplies from IDPL representatives, check them and issue the necessary receipt for the total number of medicine kits received kits, found in sound condition and kits found in damaged condition. Copies of such receipts should be furnished by them to the State Government and this Ministry within 7 days from the date of receipt of the kits.

5. Copies of the precise instructions issued by the State Government may be endorsed to this Ministry.

Integrated Child Development Services—Information for Anganwadi Workers on Diseases in General and Use of Medicine Kit in Particular.

This Kit contains the following medicines and related articles :—

Sl. No.	Item	Form	Quantity
1.	2	3	4
1.	Aspirin tablets	300 mg.	1000 tablets
2.	Sulphadimidine tablets	500 mg.	500 tablets
3.	Mebendazole tablets	100 mg.	450 tablets
4.	Benzoyl Benzoate	25% solution	500 ml.
5.	Tetracycline eye ointment	3.5 gm. tubes	10 tubes

1	2	3	4
6.	Sulphacetamide eye drops, with dropper	20% solution; 14 ml. bottle	6 bottles
7.	Gentian Violet	2% so paint	450 ml.
8.	Iodine	2% solution	450 ml
9.	Chlorine tablets	0.5 gm	1 bottle of 100 tablets
10.	Antiseptic lotion	500 ml. bottle	One bottle
11.	Cotton wool	400 packs	2 packs
12.	Bandage	5 cm. wide × 5 metres	1 dozen
13.	A pair scissors (in initial supply only)	Make 0404 of IDPL	One

2. In addition, the following medicines would be made available to the anganwadi worker by the P.H.C. or the sub-centre :—

Sl. No.	Medicine
1.	Chloroquine Tablets;
2.	Vitamin 'A' Solution and
3.	Iron and folic acid tablets.

Appendix VI

Copy of the letter No. 14-34/84-CD dated 10 October 84

Subject : Selection and advance action for new ICDS projects.

At the Conference of Social Welfare Ministers on 28th September 1984, the Union Minister of Social welfare had announced that 200 additional ICDS projects will be initiated during the current year against the allocation for 1985-86. It has since been decided that advance action for———— ICDS projects may be initiated in your State/UT during the current year. In particular, such advance action should include sanction, appointment and training of CDPOs, Supervisors and, wherever possible, Anganwadi Workers.

2. The actual size of the Annual Plan (1985-86) has not yet been decided. When the Annual Plan (1985-86) is finalized, the aforesaid allocation will be adjusted in the final allocation of ICDS projects to your State for the year 1985-86 (which, in any case, will not be less than the figure indicated above).

3. In the selection of areas for the location of these additional ICDS projects, priority should be given to the following :

(a) Tribal development blocks;

(b) Slums in towns/cities having population of 2 lakhs or more; and

(c) Backward rural areas i.e. community development blocks having a large proportion of Scheduled Caste population, drought prone areas, areas deficient in nutrition, areas deficient in social welfare services.

4. In urban slum ICDS projects, the health staff will continue to be provided by the Ministry of Social Welfare. In rural/tribal ICDS projects, the strengthening of health staff will have to be undertaken by the State Department of Health by utilising Central assistance available from the Ministry of Health and Family Welfare. In the selection of blocks for the location of new ICDS projects, therefore, necessary coordination should be established with the State Health Department. Priority should also be given to the selection of blocks located in area-project districts (i.e. districts in which the rural health infrastructure is being especially upgraded by the Ministry of Health and Family Welfare), if there are any such districts in your State/UT.

5. The State Government will have to meet the cost of the supplementary nutrition component of the new ICDS projects. During the current financial year, expenditure on nutrition in respect of new projects is not anticipated because the initial period will be spent in sanction, appointment and training of CDPOs, Supervisors and Anganwadi Workers. However, provision for supplementary nutrition will have to be made by the Stase/UTs in the budget for 1985-86.

6. In respect of rural/tribal ICDS projects, necessary coordination should also be established with the Public Health Engineerring Department in your State/UT in order to ensure that water supply arrangements are provided on priority basis in the problem villages in the blocks that may be selected for new ICDS projects.

7. Names of blocks/slum areas suggested for the location of new ICDS projects may be sent to this Ministry along with background information in the enclosed format so as to reach this Ministry before 31 October 1984. Such information may be sent in respect of twice the number of ICDS projects for which advance action is approved as mentioned in paragraph one above. This will also enable this Ministry to select and approve additional blocks/slums from the said lists when the Annual Plan (1985-86) is finalised.

8. Advance action may be started without waiting for any separate financial sanction. Additional funds required for advance action during the current year will be released to the States/UTs as part of the consolidated grants for ICDS in the subsequent instalments.

Background information in respect of Block recommended for location of ICDS Projects.

1. Name of the Block and District in which situated :
2. Population of the Block (1981 Census) :
3. Area of the Block :
4. Distance of Block H.Q. from District H.Q. :
5. Total number of villages in the Block :
6. Number of villages having safe water supply :
7. Number of villages having primary schools :
8. Number of villages having Balwadis :
9. Number of villages having SNP Centres :
10. Whether ANP block, if so number of villages covered :
11. Number of villages having Mahila Mandals :
12. Number of villages having irrigation facilities :
13. Location of PHC :
14. Is MPW scheme of Ministry of Health and Family Welfare implemented in this block ?
15. Is CHV Scheme of Ministry of Health and Family Welfare implemented in this block ?
16. Number of Primary Health Sub-centre :
17. Number of doctors, LHVs/PHNs, ANMs and other staff at PHC :
18. Major diseases in the Block affecting children :
19. Whether any voluntary organisation active in the block :
20. Percentage of Tribal population :

21. Percentage of Scheduled Caste Population :

22. Whether declared backward area :

23. Whether a drought prone area :

24. Whether nutritionally deficient area,
If so on what basis :

25. Distance of the block from the nearest Medical college with name of medical college :

Copy of the letter No. 6-7/84-CD dated 18 October '84

Subject : Integrated Child Development Services (ICDS) Scheme—Expenditure on vehicles provided to Medical Officers in Urban ICDS projects.

As the State Governments and Union Territory Adminstrations are aware, a separate vehicle is provided to the full-time Medical Officer in each Urban ICDS project. Questions have been raised in respect to this vehicle as to who would bear the cost of POL and to what extent and who would bear the cost on salary of the driver.

2. These questions have been considered by this Ministry and the following decisions have been taken :

(a) Expenditure upto Rs. 15,000/- per annum, per Urban ICDS project, may be incurred on POL for the vehicle. This expenditure can be met from the Central grants under ICDS.

(b) The State Government/Union Territory Administration should endeavour to provide drivers for these vehicles from the strength of the State/Union Territory Health Department. However, if it is not possible to do so, there will be no objection to the expenditure on salary for the drivers being met by Central grants under ICDS.

3. The State Government/Union Territory Adminstration are requested to consider the matter in consultation with their Health Departments and take appropriate action. This Ministry may please be kept informed about the precise practice being followed in your State/Union Territory.

Copy of the letter No. 19-43/84-CD dated 16 November 84

Subject : Integrated Child Development Service (ICDS) Scheme—Filling up of vacant posts of female multi-purpose workers in sub centres covered under—

It has been reported to the Government of India that a large number of posts of female multi-purpose workers are lying vacant in the ICDS blocks. It has also been observed that the State Health Departments are not giving due priority to the provision of health components in the areas covered by the ICDS. This matter had been taken up with the Ministry of Health and Family Welfare who have since addressed the Health and Family Welfare Departments of different States and Union Territories demi-officially. A copy of that Ministry's D. O. letter No. 18019/2/84-RHD dated 9/12.11.84, addressed to Health Secretaries of States and Union Territories, is enclosed.

2. It is requested that the matter may please be taken up with the Health and Family Welfare Department of your State/ Union Territory with a view to ensuring that health staff in the ICDS blocks in your State/Union Territory is posted on priority basis.

A copy of the letter No. 18019/2/84-RHD dated 9/12 November, 1984 from Shri P. R. Das Gupta, Joint Secretary, Ministry of Health and Family Welfare, Nirman Bhavan, New Celhi.

It has been observed by the Planning Commission that large number of posts of female multi-purpose workers are lying

vacant in ICDS blocks. It has been observed that the Health Department is not giving due priority for providing health components in ICDS areas. In this regard I would like to draw your attention to the Ministry of Health and Family Welfare letter No. P. 18019/2/84-RHD dated 11-10-84 wherein it is stated that before establishing additional sub-centres highest priority should be given for filling up the vacant posts of female multi-purpose workers in sub-centres cövered under the Area Projects, ICDS blocks, tribal and hilly areas. I shall be grateful if you please ensure that health staff in ICDS blocks are posted on priority basis.

Copy of the letter No. 6-7/84-CD dated 20 November 84

Subject : Integrated Child Development Services (ICDS) Scheme – Expenditure on vehicles provided to Medical Officers in Urban ICDS project.

In this Ministry's telegram of even No. dated 28.3.84 it had been indicated that an additional jeep would be provided to the whole time Medical Officer in an urban ICDS project. Subsequently, in this Ministry's letter of even No. dated 18.10.84, the position in regard to the cost of POL and the salary of driver of such vehicles had also been clarified. It has been brought to the notice of this Ministry that certain State Governments/ Union Territory Administrations are still not aware of the correct positions in this regard. Accordingly, it is hereby clarified again that, in Urban ICDS project, a jeep would be provided for use by the whole-time Medical Officer for the project. This jeep will be in addition to the jeep already provided to the CDPO of the project. A copy of this Ministry's letter of even No. dated 18.10.84 clarifying the position relating to the cost of POL and salary of the driver for this additional vehicle is also enclosed for ready reference.

2. It is requested that the position in these communications may please be brought to the notice of all concerned. Wherever the consignees' addresses for the jeeps intended for full time Medical Officers for Urban ICDS projects have not already been furnished, the same may please be furnished to this Ministry immediately, under intimation to the Zonal Office of UNICEF. It will be appreciated it this matter is dealt with on priority basis.

Extracts from the letter No. 2-15/84-CD dated 19 Jan. 85

Subject : Cost of P O. L. and maintenance of P. H. C. Vehicles serving in I. C. D. S. Programme.

An amount of Rs. 6000/- to to 7000- per annum can be made available, for additional utilization of the P. H. C. vehicles to the medical officers for more frequent visits to sub-centres and anganwadi centres in all the Centrally-sponsored ICDS projects, out of the budgets of Rs. 30,000/-, Rs. 15,000/- and Rs. 25,000/-provided for P. O. L. of a rural, urban and tribal project respectively.

Appendix XI

Copy of the letter No. 1-4/84-NT dated 19 January 85

Subject : Special Nutrition Programme-Revision of cost pattern etc.

An ad-hoc interim revision of the unit cost for supplementary nutrition under the Special Nutrition Programme (SNP) was indicated in this Ministry's letter No. 11-12/84-NT dated 27 September 1984 (copy enclosed for ready reference) to enable the States/U Ts to prepare budget estimates (both plan and non-plan) for SNP from 1985-86 onwards. It was also mentioned in that letter than an Expert Group has been set up to revise the cost of supplementary nutrition in ICDS/SNP. The Expert Group has now concluded its recommendations which have been considered by the Ministry.

2. The level of nutrition supplements to children and mothers in ICDS/SNP may be as fellows :-

I. Children (6 months-72 months) : 300 calories and about 10 grams of protein.

II. Severely malnourished children (6 months-72 months) : 600 calories and about 20 grams of protein.

III. Pregnant women (last trimester) and nursing mothers (first six months of lactation) : 500 calories and about 20 grams of protein.

3. Where aid food from CARE/WFP is being utilised for nutrition supplements and the approved ration implies a higher supplementation than the above mentioned limits, such approved ration may continue to be followed. In the utilisation of

aid food from CARE/WFP, a pattern of double ration for mothers i.e. double the quantity of ration prescribed for children who are not severely malnourished, is generally followed. That may be continued.

4. The consolidated unit costs of nutritional supplements are revised effective from 1 April 1985, as mentioned below :

I. Children (6 months-72 months)	:	75 paise per child per day
II. Severely malnourished children (6 months-72 months)	:	125 paise per child per day
III. Pregnant women and nursing mothers	:	105 paise per beneficiary per day

5. The detailed break-up of these unit costs is shown in the enclosed Annexure. It will be seen that the aforesaid unit costs are applicable for the utilisation of indigenous food for nutrition supplements and include the costs of food (whether locally cooked or processed), transport, administration, fuel and condiments.

6. In ICDS projects, the entire administration is financed with grants given by this Ministry. Therefore, the unit costs for nutritional supplements in ICDS projects will be less by 10 paise per beneficiary per day. Thus, the unit costs for nutritional supplements in ICDS projects will be as mentioned below :

I. Children (6 months-72 months)	:	65 paise per child per day
II. Severely malnourished children (6 months-72 months)	:	115 paise per child per day
III. Pregnant women and nursing mothers.	:	95 paise per beneficiary per day

7. Where WFP/CARE food is utilised for nutritional supplements budget provision has to be made towards costs of

transport, administration (except in ICDS projects), fuel and condiments. This would be at a consolidated rate of 6 paise per beneficiary per day (20 paise per beneficiary per day in ICDS projects).

8. Any further expansion of SNP should only be undertaken as part of the ICDS programme. Expansion of SNP outside ICDS project areas should be discouraged as the expansion is generally not found to lead to an appreciable beneficial impact on the health and nutritional status of children. On the other hand, it is necessary to ensure that adequate funds are provided and utilised for uninerrupted supplies of food for continuous delivery of nutritional supplements to children and mothers in ICDS project areas.

9. In addition to the unit costs mentioned in the preceeding paragraphs non-recurring provision of Rs. 800 per anganwadi (for all new nganwadis) should be made in the SNP budget in order to meet the cost of utensils for cooking the food, feeding the children, stove/hearth. Provision may also be made for replacement of utensils etc, if necessary, at periodical intervals of about five years.

10. The guidelines for making non-plan budget and plan provision for SNP in 1985-86 and subsequent years, as mentioned in paragraphs 3 and 4 of this Ministry's letter No. 11.12/84-NT dated 27 September 1984 (copy enclosed), may continue to be followed. If any state finds it difficult to provide sufficient non-plan budget in 1985-86 according to the revised unit costs for the coverage reached at the end of the Sixth Plan, the differential costs between the existing patterns and the revised pattern of unit costs can be provided in the plan budget and the amount as per existing pattern of the non-plan budget.

11. It is suggested that the revised unit costs fo SNP may also be followed for MDM with effect from 1 April 1985.

12. The following recommendations, arising from the conclusions of the Expert Group, may also be considered favourably and adopted by the State Governments/UT Administtations :—

(a) Expansions of MDM Programme in ICDS Project areas;

(b) On-the-spot feeding as far as possible, as the delivery method of nutritional supplements;

(c) Use of ready-to-eat foods (i.e processed RTE foods) in substantial quantities, especially for certain specific purposes; weaning foods for infants; therapeutic food for severely malnourished children; supplements to other children below 3 years age;

(d) Exemption of food supplements from taxes and duties likes Sales Tax and Octroi and

(e) Monitoring of the food delivery system.

13. This Ministry has separately invited proposals from the State Governments/UT Administrations for establishment of food processing plants for production of ready-to-eat foods. This Ministry will also be issuing, in due course, detailed guidelines on the monitoring of the food delivery system but, in the meantime, the existing monitoring procedures may continue to be followed.

Copy of the letter No. 11-12/84-NT dated 27 September 85

Subject : Plan and Non-Plan Budget for SNP from 1985-86 onwards.

The Secretary, Planning Commission, has written a D.O. letter No. PC (P)/1/7/1/84 dated 27 August 1984 to the State Governments, inviting proposals for the Seventh Five Year Plan (1985-90) and Annual Plan (1985-86). An extract from para 5 of that letter is reproduced below :—

"The current year i.e. 1984-85 being the terminal year of the Sixth Plan, the level of maintenance expenditure in the Plan would become a committed liability and would require to be transferred to the Non-Plan side in accordance with the past practice....."

2. This is consistent with the report of the Eighth Finance Commission. The Finance Commission had also stipulated that the maintenance of plan schemes (upto 1984-85) will become the committed liability (to be met from State/U.T. Non Plan Budget from 1985-86) onwards.

3. The Non-Plan Budget for SNP in 1985-86, therefore, should include adequate provision for the following :—

(a) Charges for clearance and handling of aid food commodities at the ports, storage at various points, transportations upto anganwadis/feeding centres, processing, administrative costs payable to CARE etc. (in respect of States/UTs which are receiving CARE/WFP food commodities for SNP and/or supplementary nutrition in ICDS projects);

(b) Cost of transport, administration, processing etc. in respect of food procured with State funds;

(c) Operational costs of existing processing plants for production of foods for SNP and/or supplementary nutrition in ICDS projects;

(d) Cost of fuel, condiments etc. in respect of food commodities which are cooked at the anganwadis or feeding centres;

(e) Cost of food in respect of the number of beneficiaries who are at present covered from Non-Plan Budget for SNP.

(f) Cost of food in respect of the number of beneficiaries (in ICDS projects as well as in SNP centres outside ICDS projects) who are expected to be covered from the plant budget for SNP by the end of the year 1984-85;

(g) State sector ICDS projects taken up by the end of the year 1984-85; and

(h) Any other item the expenditure on which is currently met from the Non-Plan Budget for SNP.

4. The plan budget for SNP from 1985-86 onwards should include provision for the following items :—

(a) Entire cost of supplementary nutrition in respect of additional number of beneficiaries to be covered beyond the level already reached in March 1985 (it is suggested that such expansion from 1985-86 onwards should only be done as part on the ICDS programme);

(b) Upgradation of existing SNP (outside ICDS project areas) on the lines of the ICDS programmes;

(c) New State sector ICDS projects;

(d) Cost of cooking arrangements (stove or hearth cooking utensils, feeding utensils etc) at anganwadis in new ICDS projects—both centrally sponsored and State sector;

(e) Cost of establishing and operating new processing plants for the production of ready-to-eat nutritious foods for utilisation in ICDS projects; and

(f) Any other item that may be considered necessary by the State/UT.

5. A tentative distribution of ICDS projects for the year 1985-86 has been circulated to the States as part of the agenda notes for the Conference of Social Welfare Ministers and Secretaries (27-28 September 1984). The requirement of plan budget for additional beneficiaries in 1985-86 may be calculated on that basis for the purpose of preparing Annual Plan (1985-86) proposals.

6. An Expert Group has been set up to revise the unit cost of supplementary nutrition in ICDS/SNP. The final report of the Group has not yet been received. However, on the basis of the discussions held by the Expert Group so far, it is requested that while making non-plan and plan budget provisions for SNP in 1985-86, the following pattern may be adopted :—

(a) 30 paise per child per day, 50 paise per pregnant women/nursing mother per day and 60 paise per severely malnourished child per day toward the cost of

food (it is suggested that food articles for supplementary nutrition may, as far as possible, be supplied from the public distribution system);

(b) 15 paise per beneficiary per day towards the cost of transport and processing (including fuel and condiments in case of on-the-spot cooking); and

(c) Rs. 800/- per anganwadi in new ICDS projects (both centrally sponsored and State-Sector) for cooking arrangements i.e. stove/hearth, cooking utensils and feeding utensils.

7. Information in the enclosed proforma may please be furnished to this Ministry before the end of October 1984. The information should include consolidated figures of both and plan non-plan beneficiaries (anticipated at the end of 1984-85).

Recommendations

1. (a) The nutrition supplement under supplementary feeding and mid-day meal programmes should be as follows :

Children 6 months-6 years	...	300 KCal containing 10-12 g. of protein.
Lactating and pregnant women	...	500 KCal containing 20-24 g. of protein.
Severely malnourished children	...	600 Kcal containing 20-24 g. of protein.

(b) No. of feeding days ... 300 days in a year.

Unit Cost of food Supplement Per Beneficiary

Item	Children 6 months to 6 years		Severely malnourished children		Pregnant and nursing mothers	
	For on the spot cooking	For processed food	For on the spot cooking	For processed food	For on the spot cooking	For processed food
I	II	III	IV	V	VI	VII
1. Food cost	45	50	90	100	75	80
2. Transport, Administration, Fuel condiment spices and vitamin fortification						
(a) Transport	10	10	10	10	10	10
(b) Administration	10	10	10	10	10	10
(c) Fuel, condiment spices and vitamin fortification	10	5	15	5	10	5
Total	75	75	125	125	105	105

Appendix XII

Copy of the letter No. 15-3/85-CD dated 23 February 85

Subject : Integrated Child Development Services (ICDS) Scheme—Supplies of medicines for use in anganwadis.

I am directed to invite a reference to this Ministry's letter number 15-1/83-CD dated 18.8.84 which indicated that this Ministry had arranged the supply of medicine kits for use at Anganwadi level in all ICDS projects. The Indian Drugs and Pharmaceuticals Ltd (IPDL), through whom the first of such supplies was being arranged, has already started delivering the medicine kits to designated district level officers and it is hoped that this delivery would be completed by the end of March 1985, in all States and Union Terriories. It must be ensured that the concerned District level officials supply the medicine kits to anganwadis in ICDS projects without any loss of time.

2. Indent had been placed on the IDPL for supply of medicine kits catering to the requirement of all ICDS projects in a particular district. While determining this number, the requirement of all anganwadis in those projects, as available in this Ministry, had been taken into account.

3. There may be certain contingencies like starting of additional anganwadis, non receipt of medicine kits or its timely replenishment etc., which may necessitate some temporary arrangement for continued availability of medicines in all anganwadis. This question has been considered by this Ministry. It has been decided that expenditure upto Rs. 3000/- per Centrally-sponsored ICDS project per annum may be incurred

from Central ICDS grants in one or more of the following contingencies :

(a) Opening of additional anganwadis for which centrally arranged medicine kits are not available immeditaely.

(b) Delay in receipt of medicine kits in a particular project, or in respect of its timely replenishment.

(c) Replacement of any particular medicine (s) in the kits on account of its full utilization well before the expected arrival of the next instalments of medicine kits.

4. The above provision for local procurement of medicines is available only in respect of those medicines which are included in the medicine kits for Anganwadis being supplied by this Ministry.

Appendix XIII

New system of distribution of honoraria to chief district advisers, district advisers, project advisers and sector advisers

A new system of disbursement of honoraria to different level functionaries in ICDS viz. Chief District Advisers, District Advisers, Project Advisers and Sector Advisers, has been implemented from 1st April, 1987 in selected states of the country. The new system facilitates accounting procedures at the central and district level and also helps in upto date distribution of honoraria to the most peripheral ICDS functionaries.

Under the new system a duly filled proforma indicating the honoraria due to each—the Chief District Adviser, District Adviser, Project Adviser and Sector Adviser—is prepared by the Central Cell on the basis of reports received indicating functions carried out in last 3 months. The duly filled proforma is sent to the Chief District Adviser who claims the money for the functionaries by sending a pre-receipted voucher.

The Chief District Adviser makes the payment, gets the receipts of money paid to various functionaries and sends these receipts to Central Cell.

However, for accounting purpose, it is the pre-receipt which is considered by central cell for sending honorarium to the Chief District Adviser.

Suggested Programme for Crash Orientation & Training Courses in ICDS

It was decided at the Consultants' Meeting in Delhi on 14/7/87 that crash courses should be held immediately in states where a large training backlog exists. The need was expressed to modify the course curriculum in such a way that theoretical training is minimised and acquistión of skills is maximised. In this background, the following programme is suggested by the Central Technical Cell of the ICDS.

Suggested Programme for 3 day Crash Courses in ICDS
First Day

I. *Introduction to ICDS*

a) Concept

b) Objective

c) Services provided :
to mothers
to children

II. *Organisation of ICDS*

a) Social Welfare component

b) Health component

c) Role of functionaries at different levels

III. *Monitoring and Feedback in ICDS*

a) Reporting system in Health
Filling AWW proforma
Filling Sectoral Adviser proforma
Filling Project Adviser Report
Filling DA & CDA reports
Definitions/explanations of the terms used in various forms

b) Brief outline of Reporting system in Social Welfare' Nodal Department.

c) Feedback from the Central Cell based upon reports received

To State level
To District level

IV. Important Administrative and Financial Aspects

a) Contents of the relevant appendices in the Red Book titled "Monitoring and Continuing Education System".

b) Financial assistance in Monitoring System.

c) Intersectoral coordination.

Suggested Programme for the Crash Courses for Second day

V. Review of ICDS implementation of sectoral meeting

a) Infant deaths and their causes

b) Maternal deaths and their causes

c) Review and planning of immunisation

d) Prevalence of moderately and severely malnourished children

e) Interaction between AWW & ANM

f) Visits of higher functionaries to AW

g) Number of referrals from AW

h) AW reporting/not reporting to sector advisor

i) Availability of medical kit

j) Use of Medical kit

k) Distribution of Iron, folic acid and vitamin A

l) Review of HNE (Health and Nutrition Education)

VI. Training and continuing education

a) Sectoral level training

b) Block level training

c) District level training

VII. Role of ICDS Consultants in training, survey and research and monitoring of urban projects (in brief)

VIII. Half day field visit/discussion – A field visit may be organised if feasible. As regards venue, time and facilities available, if field is not feasible, this may be replaced by a half day session to discuss the functioning of ICDS projects and the problems and bottlenecks encountered and their solutions. This discussion should be based upon actual experience of medical officers and of a few other functionaries (ANM, LHV, CDPO, supervisor, AWW) who should be invited for this session.

Suggested Programme for the Crash Courses for Third Day

IX. a) Updating of Health and Nutrition Concepts

a) Nutrition (Principles of nutrition. Special nutritional needs of women and children. Assessment of nutritional status. Nutritional supplementation.

b) Antenatal, natal, postnatal care

c) Breast feeding and weaning

d) Growth and development

e) Immunisation

f) Diarrhoea and oral rehydration

g) Health and nutrition education

h) Health check up, referral and treatment of minor ailments

i) Risk approach

j) National nutrition programmes

Note :

1. The plan suggested above is tentative. Suitable modification may be incorporated as per local needs.

2. If the course is planned for a period lesser than 3 days, necessary changes may be made. Field visit may have to be left out. Time devoted to item IX (Health and Nutrition concepts) may have to be reduced by 50% or more.

3. Topics discussed in item IX should be need based depending upon perceived and expressed needs of course participants. Topics may be deleted/added as necessary.

4. While allocating time for various topics and while conducting the courses for a shorter duration, it should be remembered that topics 1–5 are of crucial importance. Topics 3 and 5 are particularly so.

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